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SACHI A. HAMAI
Chief Executive Officer

July 6, 2018

To: Supervisor Sheila Kuehl, Chair
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Janice Hahn
Supervisor Kathryn Barger

From: Sachi A. Hamai
Chief Executive Officer

REPORT BACK ON A PROPOSED COUNTYWIDE MULTI-YEAR STRATEGY TO SUPPORT THE SELF-SUFFICIENCY GOALS OF TRANSITIONAL AGED FOSTER YOUTH (ITEM NO. 16, AGENDA OF AUGUST 22, 2017)

On August 22, 2017, the Board of Supervisors (Board) adopted a motion that recognized Transitional Aged Youth (TAY) who age out of the foster care system from the Department of Children and Family Services (DCFS) and Probation Department (Probation), as the most vulnerable within Los Angeles County's disconnected youth population, as evidenced by poor young adult outcomes. As such, the Board motion ordered the following:

- Direct the Chief Executive Office (CEO) in conjunction with the Office of Child Protection, to coordinate with all relevant County departments to coalesce existing efforts as the basis for a cohesive multi-year strategy that will support the self-sufficiency goals of transitional aged foster youth at the earliest stage possible. Specifically, this should include:
    - Identification of all existing programs, services, funding streams and working groups that serve transitional aged youth/AB 12 youth (including any shortfalls or gaps in service or ineffective programs, as well as any successful initiatives for consideration of full implementation);
    - Involvement and input of senior level staff within each relevant County department (and across department divisions), along with key internal and external stakeholders and advocates;
    - Identification of lead departments for each goal and objective, which will serve as the basis for ongoing Management Appraisal and Performance Goals

(MAPP) for department directors until the plan is implemented and fully-operational; and
- Data indicators (including base data and anticipated outcomes) and strategies for evaluation of implementation efforts.

The Board further directed: 1) the CEO's Legislative Affairs and Intergovernmental Relations to amend the County's legislative agenda to strengthen the County's support for TAY; and 2) the Office of Child Protection (OCP) and CEO "to identify existing community projects related to transitional aged foster youth and engage the philanthropic community and other community partners that currently have projects, resources and services in place."

TAY Report Highlights

CEO's response to the multi-year strategy to improve TAY outcomes is detailed in the report, "Los Angeles County Centralized TAY Hub: Supporting Successful Transition of Foster Youth to Adulthood" and includes the responses from Legislative Affairs and Intergovernmental Relations, and the OCP (See Attachment I).

The following are key highlights from the report's multi-year TAY support strategy:

- CEO convened a TAY Countywide Departmental Self-Sufficiency Committee (Committee), consisting of 12 key departments that provide TAY resources and supports, to fully assess intra-departmental and inter-departmental processes for informing and engaging TAY and their support network (including County staff and caregivers) about their services.

- The Committee's work resulted in commitments towards better serving the TAY population including commitments to: 1) align the County's myriad of available resources for TAY within the County's Service Planning Areas structure, based on allocating them on placement data trends on where TAY reside; 2) maximize the use of the County's non-traditional TAY assets to more effectively engage TAY to use available countywide resources, such as the use of community-based sites for service delivery, including local parks, public libraries, and faith-based organizations; and 3) coordination of countywide TAY service/program delivery plans (i.e., through a master calendar) to maximize program and funding availability, and to address identified gaps in information delivery strategies.

- The solution to meet the inter-departmental commitments resulted in the proposed development of an online system called the Centralized TAY Hub, with its main objectives as follows:

  - Centralizes online countywide TAY resources and supports in one place;
  - Provides continuous online accessibility to TAY and their support network online; and
  - Curates specific strategies that engage TAY through the Hub (such as interaction with live peer-to-peer trained and hired foster youth).

- Community stakeholder forums were held in March and April 2018 to receive feedback on the Committee's work and its proposed concept of creating the Hub. Feedback received from 269 stakeholders (TAY, County staff, and caregivers) participating in 15 forums across the County was highly positive, as detailed in the report.

- A final feedback forum for the Hub was the May 3, 2018, Children and Family Services and Probation Departments' Annual System Improvement Plan Stakeholder Conference, which focused on these departments' work on federal outcomes for TAY. The Hub concept was spotlighted at the event and received high praise from the nearly 400 attendees. Participants also provided concrete suggestions and input on how the Hub should function to fully engage TAY and their support network, which will be invaluable in guiding the early steps in developing the system.

- A multi-year project plan (Prepare, Roll-Out, and Implementation phases) is provided, with two key preliminary steps before the project plan can begin: 1) identification of an entity (internal or external), that can effectively build the proposed concept, with a preference for a public-private sector partnership; and 2) exploration of non-County funding opportunities to pay for the planning, development and implementation of the proposed concept.

Proposed Next Steps

Finally, the CEO is prepared to initiate the following steps to begin the work of creating the Centralized TAY Hub, upon the Board's acceptance of the report:

1. CEO will explore internal (County) and external (private sector, philanthropy, etc.) options to: a) identify an entity with the expertise to realize the Centralized TAY Hub, and to determine any necessary agreements; and b) external options to fund the project.

2. CEO, with OCP and full participation with relevant County departments in the proposed roles defined under the Prepare, Roll-Out, and Implementation section of the attached report, will also implement a governance structure (i.e., Advisory Boards) that includes key internal and external stakeholders and advocates to guide the implementation of the multi-year strategy.

3. CEO will work directly with relevant Department Heads to develop Management Appraisal Performance Program goals directly related to fully support all Prepare, Roll-Out, and Implementation phases of the Centralized TAY Hub, as outlined in the report.

If you have any questions or need additional information, please contact me directly, or your staff may contact Fesia Davenport at (213) 974-1186 or by email at fdavenport@ceo.lacounty.gov.

SAH:JJ:FAD
HK:km

Attachments

c. Executive Office, Board of Supervisors
County Counsel
Children and Family Services
Consumer and Business Affairs
Health Agency
Health Services
LA County Library
Mental Health
Office of Child Protection
Parks and Recreation
Probation
Public Health
Public Social Services
Workforce Development, Aging and Community Services
Los Angeles County Office of Education
Los Angeles Homeless Services Authority

Los Angeles County Centralized Transitional-Aged Youth Hub

Supporting the Successful Transition of Foster Youth to Adulthood

Chief Executive Office, Service Integration Branch

July 17, 2018

Background: Proposal for a Centralized Transitional-Aged Youth Resource and Support Hub (Centralized TAY Hub)

Foster care is supposed to be a temporary refuge for children who have been abused and neglected, or for children whose parent(s) can no longer provide adequate care. It was never intended as a permanent living arrangement. Yet too often youth grow up in foster care and age-out without permanency - i.e., being united with a caring family or adult prior to aging out of the foster care system. Research shows that youth who exit from foster care without a permanent family or connection, have a higher risk for many poor outcomes, including lack of education,
teen pregnancy, unemployment, poverty, homelessness, and involvement with the criminal justice system. Increasing permanency efforts will decrease the number of transitional-aged youth (TAY). For TAY whom permanency may not be an option, it is important that youth become self-sufficient and resilient.

On August 22, 2017, the Board of Supervisors adopted a motion acknowledging the poor outcomes that many foster youth (including both Department of Children and Family Services (DCFS)-supervised and Probation-supervised youth) face. Moreover, the Board acknowledged that "individual departments cannot effectively serve a child in isolation" and asked for a "culture change countywide to integrate support for self-sufficiency of foster youth throughout all County services - from pregnancy prevention to mental health services, from educational obtainment to career development, and stable housing programs."

In response to this motion, the Chief Executive Office (CEO) presents this report containing a multi-year strategy aimed at helping TAY and their support network (including County staff and caregivers) to address resource and support needs to strengthen their self-sufficiency and resiliency efforts.

Recent County statistics of TAY reflect the need for a countywide organizational change (see Figure 1). Los Angeles County currently has over 5,000 TAY between the ages of 16 and 21 years old, with active cases with DCFS and/or Probation. A recent CalYOUTH study of Assembly Bill 12 (AB 12) TAY participants from California found that less than 20 percent of TAY reported that they feel fully prepared to be independent when they age out of the system (Chapin Hall, 2014). Another study on post-system outcomes (four years after leaving jurisdiction) for the TAY population continues to show disconcerting self-sufficiency outcome

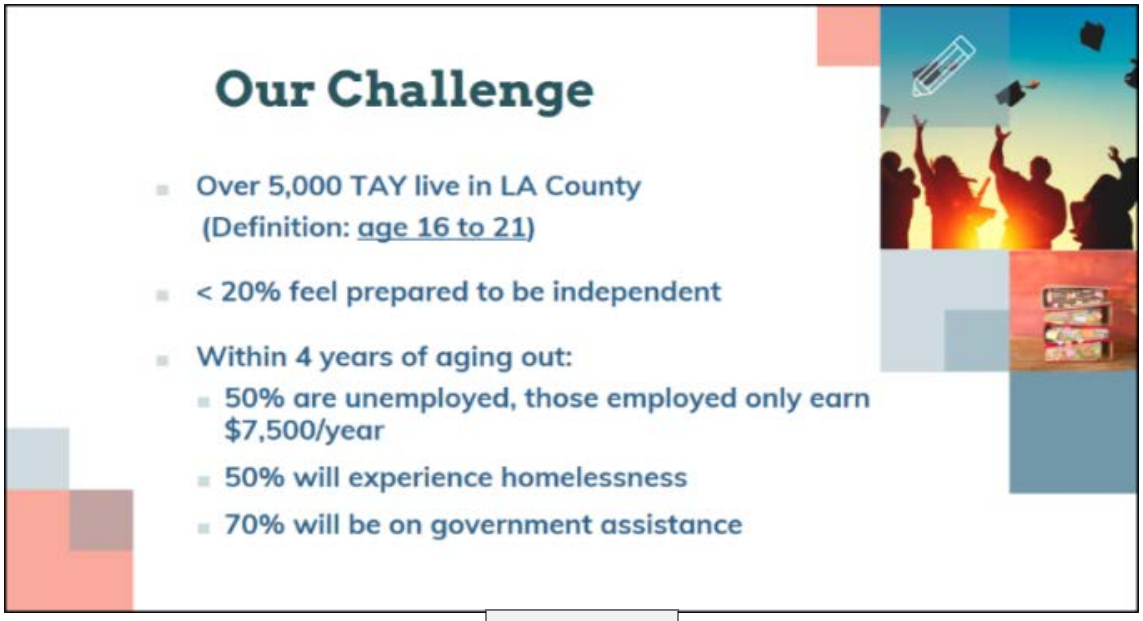


Figure 1

trends: 50 percent are unemployed and those who are employed earn on average an annual income below the poverty line ($7,500); 50 percent experience a period of homelessness; and 70 percent will receive governmental assistance to survive (Hilton Foundation, 2013).

To address these undesirable outcomes, the motion directed the CEO and the Office of Child Protection (OCP) to do the following:

1) Identify a cohesive multi-year strategy that would support the self-sufficiency goals of TAY at the earliest stage possible (CEO);

2) Amend the County's legislative agenda for Federal and State legislation to better support successful self-sufficiency of foster youth (CEO); and

3) Engage philanthropic community partners with identified existing TAY community projects, who have resources and services in place, to maximize resources to "coordinate, integrate and develop promising pilot projects" (OCP).

I. Convening the TAY Countywide Departmental Self-Sufficiency Committee

In response to the first directive, the CEO's Office: convened the Countywide Self-Sufficiency Committee; conducted an assessment of Countywide TAY programs and services; and identified areas where improvements could be made for disseminating information to and engaging TAY.

Convening the Committee

First, the CEO convened the Countywide Self-Sufficiency Committee. The Committee was comprised of 12 key County departments and entities representing those who provide key self-sufficiency resources needed by TAY to meet their self-sufficiency goals, as well as the CEO and two other offices that provide support for those goals. The departments included: DCFS; Consumer and Business Affairs (DCBA); Health Agency (including the Departments of Mental Health, Public Health, and Health Services);
Los Angeles Homeless Services Authority (LASHA); Office of Education (LACOE); Parks and Recreation (Parks); Probation; LA County Library (Library); Public Social Services (DPSS); and Workforce Development, Aging and Community Services (WDACS). The OCP and Center for Strategic Public Private Partnerships (CSPPP) also served on the Committee.

Committee members were briefed on: 1) current countywide initiatives and related Board motions aimed at improving the outcomes of TAY; 2) demographic statistics on the County's current TAY population and available
TAY programs and services gathered from departmental websites, as well as from 211 Los Angeles County's information and referral system; 3) current OCP action plans for addressing the TAY population; and 4) information on the general TAY population from recently published studies.

Committee Assessment of Countywide TAY Programs

Each department, starting with DCFS and Probation (and the Chaffee Independent Living Program), was asked to map out their internal current strategies to both inform and engage those key support network individuals responsible for connecting TAY to their needed resources: County staff, caregivers, and TAY themselves. Committee members exhaustively documented their available TAY resources and/or TAY-related resources across acknowledged TAY self-sufficiency life skill milestones and support domains.

After mapping out all relevant County TAY self-sufficiency assets, the Committee analyzed the overall business processes and strategies for providing supportive services and resources to TAY in order to identify gaps in service delivery strategies, as well as identify successful program attributes that may be considered a countywide best practice. By using DCFS and Probation TAY placement data trends, the

Committee committed to the following inter-departmental actions:

- Align the County's myriad of available resources for TAY within the County's Service Planning Area structure, allocating the resources based on where TAY reside;
- Maximize the use of the County's non-traditional TAY assets to more effectively engage TAY to use available countywide resources, such as the use of community-based sites for service delivery, including local parks, public libraries, and faith-based organizations; and
- Coordination of countywide TAY service/program delivery plans (i.e., through a master calendar) to maximize program and funding availability, and to address identified gaps in information delivery strategies.

Committee-Identified Improvements to Deliver Information and Engage TAY

The Committee determined that any proposed strategy must include centralization of countywide TAY-specific resource and support information so TAY and their support network can easily access TAY service information in one place. An effective centralized system should have the following attributes:

- Reflect the best practice TAY engagement strategies as part of the access to and provision of TAY resource information;
- Reflect improvements of current inter-departmental communication concerning TAY-specific or TAY-related resources and supports from a stakeholder perspective (i.e., TAY, County staff, caregivers, etc.);
- Reflect strategies for leveraging of programs and funding streams across departments, within each TAY self-sufficiency domain to further support TAY and their support network (for example, program delivery locations and funding allocations based on TAY placement data trends from DCFS and Probation); and
- Reflect the improvement of inter-departmental processes for TAY and their support network to access resources and supports within each TAY self-sufficiency domain (in particular, current efforts to plan out transitional and permanent supportive housing for AB 12 youth, and provide access to mental health supportive services).

Finally, the Committee recognized the need to expand the defined age range of TAY from age 12 to age 26 to increase the effectiveness of such a system when used by County staff and caregivers. A centralized system can specifically be used in current DCFS and Probation case management practices and protocols such as:

- Child and Family Team meetings, where self-sufficiency needs and supports will be more readily available as a topic of discussion for TAY, regardless of whether the youth is in attendance;
- Continuum of Care Reform, where a centralized system would assist caregivers and providers in achieving the State's increased quality of service outcomes for out-of-home placed children and youth;
- Transitional Independent Living Plans, where planning discussions of six-month plans with TAY and caregivers by County staff can be more specific and exhaustive; and
- Meeting departmental reasonable efforts regarding TAY self-sufficiency planning and the provision of TAY-specific resources and supports.

II. Proposed Multi-Year Strategy: Creation of a Centralized TAY Resources and Support Hub (Centralized TAY Hub)

The multi-year strategy calls for a Centralized TAY Hub to be used by TAY, and their support network, including County staff, caregivers, and others who support TAY. The Centralized TAY Hub concept is a proposed web-based model that facilitates access to information, from multiple sources, intended to assist and guide TAY in meeting their self-sufficiency goals.

The Centralized TAY Hub should provide TAY with the right resources at the right time based on their progress towards meeting their identified self-sufficiency goals. In its final form, the Centralized TAY Hub should reflect a combined TAY-focused support network embedded within County departments and within on-the-ground community organizations.

Three Things the Centralized TAY Hub Should Do to Inform and Engage TAY

1. House easily accessible information online for TAY and their support network - a curated suite of resources (products, programs, and services) specifically chosen because they meet TAY needs for all of Los Angeles County including:
    - Relevant resources and knowledge from County departments (see Figure 2): Not just social services, but also consumer and business affairs, education, housing, and employment/workforce development (for example, Library has free online tutoring, Parks hosts free cooking classes, and DCBA clears credit reports for free);
    - Relevant resources and knowledge from community agencies covering basic needs, education, employment, mental health, legal, etc.; and
    - Relevant resources and knowledge from private enterprises and businesses that may offer TAY-specific supports.
2. Function as a self-service tool that will engage TAY to find what they need (or provide suggested resources), and get what they need without having to go anywhere else to learn the details about a program, apply for a program, sign up for a program or service, and so forth.

    In order to do this:

    - **Personalized Platform:** The platform should be personalized for each TAY, based on their needs and where they are on their self-sufficiency needs to employment and career development.

Figure 2. Sources of resources and knowledge

- **Intelligent Platform:** The platform should be intelligent, possessing the ability to recommend resources based on where a youth is along his/her individual self-sufficiency journey and what he/she will need to reach the next milestone.
- **Teaching Platform:** The platform should contextualize resources with "How To's" and "Learning Tools" so TAY understand how a specific resource can help them achieve their goals. For example, a college-bound TAY might not go to a "Free Application for Federal Student Aid" (FAFSA) seminar if they do not understand why completing the FAFSA form is important in the first place.
- **Access-Facilitating Platform:** The platform should have a way for TAY to apply for products, services and programs.

- **Calendaring Platform:** The platform should have the capability of sending notifications and reminders about the progress of an application, an upcoming class, and new resources and opportunities.

3. Use TAY peer-to-peer support as an engagement strategy, by employing current/former foster youth to provide phone, email, text and in-person support (in established County and community organizations' sites) to connect youth to the resources they need, when they need them.

Stakeholder Feedback About Proposed Concept

During the months of March 2018 and April 2018, the Centralized TAY Hub concept was vetted across a cross-section of key stakeholder forums, convening with TAY and those who work directly with the TAY population: County staff (DCFS and Probation) and caregivers.

The vetting forums were held in various regions throughout the County to ensure that the concept was presented throughout areas that would be representative of the County as a whole. Additionally, the concept was presented in areas of the County where the TAY population has historically been fairly large, including the Antelope Valley and South Los Angeles. In addition to the forums, the concept was presented to and discussed with the following entities: Commission for Children and Families, local child advocate groups (Public Counsel, Alliance for Children's Rights, and Children's Law Center), judicial court's Guardian Scholars Committee, and key local TAY collaboratives (including Compact Los Angeles, P3 and Opportunity Youth Collaborative).

Stakeholder Feedback Highlights

The CEO received 269 stakeholder responses across 12 forums held throughout the County: 53 caregivers, 81 TAY (of various ages), and 135 County staff.

The forums included: four TAY forums convened by California Youth Connection, Opportunity Youth Collaborative and the DCFS Teen Club Program; four caregiver forums, including kinship, Resource Family and Group Home providers; and four County staff forums, with County staff (line, supervisory, and management) from DCFS and Probation.

Key Finding: How TAY Currently Get Resource Information

One of the key questions asked of participants (County staff, TAY and caregivers) related to how TAY currently receive their information about available resources.

- The majority of County staff (88 percent) reported that TAY receive information about resources directly from County staff members, with 12 percent reporting that TAY get their information about services from various other sources (including their caregivers, peers, and other sources).

- In contrast to the responses from County staff, a smaller percentage of TAY,
  only 46 percent reported receiving information from County staff. The second most common source of information that TAY cited was from their own efforts (23 percent), followed by Other (non-specified, 12 percent) sources. Caregivers were listed as the next highest source of information (10 percent), followed by other foster youth (9 percent).

- Caregivers reported a fairly diverse set of responses for this question, including 36 percent from Other (non-specified) sources, 28 percent from County staff, 23 percent from the caregivers' own efforts, 7 percent from other caregivers, and 6 percent from the internet.

These results highlight the need to have TAY and their support networks more equipped to

support and engage TAY in achieving their self-sufficiency goals.

Key Finding: "I am well-informed about all TAY services and supports."

For this question surprisingly, TAY reported a higher level (75 percent) of agreeing with this statement than County staff (50 percent) and caregivers (42 percent). Overall, each respondent group reported being at least somewhat well-informed (45 percent to 75 percent).

Key Finding: "If the Centralized TAY Hub existed, I would use it."

In response to this question (see Figure 3), both County staff (89 percent) and caregivers (83 percent) reported that they would definitely use the Centralized TAY Hub if it existed today. Only 58 percent of TAY reported they would definitely use it. This was not surprising as stakeholder feedback on TAY engagement was cited as key to getting TAY to actively participate in utilizing resources and supports. The higher responses reported by the TAY support network appear to bode well for the success of the Centralized TAY Hub.

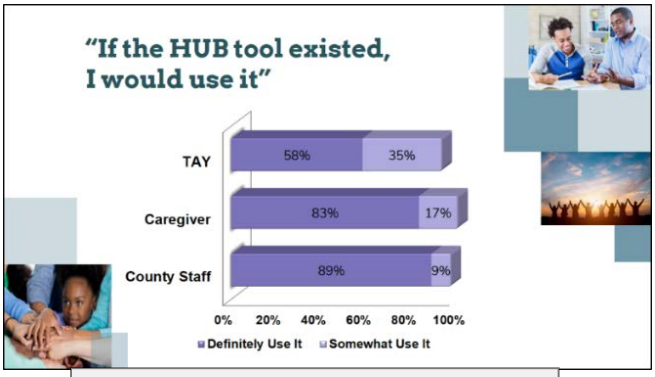


Figure 3. Opinions on prospective TAY Hub usage

DCFS Annual Systems Improvement Stakeholder Conference

Finally, the Centralized TAY Hub concept was presented to a large group of stakeholders at DCFS and Probation's Annual System Improvement Plan Stakeholder Conference (Conference) on May 3, 2018. Approximately 400 attendees attended the Conference, representing a diverse cross-section of stakeholders. Nearly 150 comments were received from participants, largely expressing positive support and enthusiasm for the concept, with suggestions on what resources to include in the system to ensure its effectiveness for all users. Another 125 written comments were received involving queries regarding the functionality of the proposed system and the confirmation of key elements/enhancements that participants wanted to be considered for inclusion into the system, should the plans for implementing the Centralized TAY Hub concept move forward.

The following are the key "Most Frequent Feedback" comments received from all stakeholders about the Centralized TAY Hub concept:

Most Liked Elements:

1. Having a centralized, "one-stop shop" location for all users;
2. Proposed use of current and former foster youth to serve as live TAY assistants; and
3. Having a system that is always available online and supported by a live person.

Must Haves for the System:

1. Resources for basic needs, with permanent housing and mental health services cited most frequently;
2. College support resources for TAY, including how to get into college and stay in college;
3. Employment support resources; and
4. Accessibility for TAY populations who are over 18 years old, including kinship youth.

Top Reasons for Not Using the System:

1. Not having an electronic device or Wi-Fi to access it;
2. Site is not easy to use for TAY and their support network; and

3. Consciously choosing not to use the proposed system; cited being "too busy" or otherwise.

Legislative Affairs and Office of Child Protection Board Responses

CEO Legislative Affairs Response to Board Directive Number 2

CEO's Legislative Affairs and Intergovernmental Relations indicated that the County's State and Federal legislative agendas recently adopted by the Board include a number of policies to support legislation that provide for successful self-sufficiency for TAY. In particular, the State Legislative Agenda, adopted by the Board on December 19, 2017, supports legislation and funding to facilitate successful emancipation, promote self-sufficiency and improve opportunities for youth aging out of foster care, and proposals to fully fund Emancipated Youth Stipends and the Independent Living Program.

Furthermore, the Federal Legislative Agenda, adopted by the Board on February 6, 2018, includes policy to support proposals and funding which would promote income security, housing, health care, education, and vocational opportunities, and economic self-sufficiency for youth emancipating from foster care, and which would lower the age provision of the Independent Living Program to 14 years. The County continues to support legislation and budget proposals to streamline foster youth's access to financial aid for post-secondary education and provide foster youth with grants to participate in extra-curricular activities, including activities directly related to skill development, academic assistance, and recreational or social participation.

Should the Centralized TAY Hub concept be implemented, Legislative Affairs and Intergovernmental Relations will remain available to consider amending the County's State and Federal legislative agendas to support that endeavor.

Office of Child Protection Response to Board Directive Number 3

The OCP worked with the CEO to identify existing community projects related to transitional-aged foster youth and engage the philanthropic community and other community partners that currently have projects, resources and services in place. Leveraging the connections and knowledge of the Center for Strategic Public Private Partnerships (Center), the OCP engaged the philanthropic community through a survey, and analyzed historical data from Southern California Grantmakers, between the years of 2014 and 2016, to better understand the landscape of supports in place for TAY.

Based on this data, 24 out of 137 grants provided in 2014-2016, funded programming that specified transitional-aged foster youth supportive programming. The grants specifically for transitional-aged foster youth in this time period focused solely on education, housing,
or supportive services in general. Throughout these three years, a total amount of $13,096,250 was awarded in grants involving all foster youth while grants specifying transitional-aged foster youth programming totaled $5,402,100. Many of the agencies identified already had established partnerships with the County.

There are some promising practices and programs that philanthropy is funding. One such program funded by philanthropy is run by the Arts for Incarcerated Youth Network (AIYN), which currently has a pilot providing high-impact, quality arts programs that are interdisciplinary and represent multiple art forms such as performing arts, writing, visual arts, and music, to at-risk youth in three LAUSD schools. This builds on the success of their work in probation camps, where AIYN coordinates programs at 10 probation sites and has reached almost 500 youth.

Due to this success, the OCP, through the Education Coordinating Council has facilitated

multiple discussions between the Department of Mental Health, the Arts Commission, and AIYN to develop a larger-scale pilot, based on a successful model that AIYN utilizes: The goal is to begin rollout of this pilot in the fall of 2018 in three to five middle or high schools, with the consideration of expanding this model throughout the County within the next few years.

Another promising area is in youth housing with two pilots in the early stages of implementation. The Center worked with the Home For Good Funders Collaborative and LAHSA to obtain private-sector funding for two pilots - one in SPA 2 and the other in SPA 3 - serving system-involved transitional-aged youth under the supervision of both DCFS and the Probation Department. Data from these pilots are being collected to determine whether these pilots should be recommended for expansion.

Finally, based on the Board's consideration of the report's next steps contained in this report, the CEO and OCP will continue to work with philanthropy and community agencies to help identify and connect the above-mentioned services and support programs, as well as leverage any other relevant and promising programs being funded by philanthropy for TAY through the Centralized TAY Hub.

Proposed Implementation Road map and Next Steps

The following comprise a proposed road map and next steps to begin working towards operationalizing the Centralized TAY Hub concept. The road map is displayed visually in Attachment III. Before initiating the road map, the CEO will first need to identify a project provider by exploring all internal (County) and external (private sector) options as part of the selection process.

Once this is completed, the following steps are proposed, with County department participation in the following roles, to begin the work:

Prepare (6-9 months) Phase: Centralized TAY Hub Planning/Development Teams

1. Create a Joint Project Leadership Team:
   - Provide overall management and oversight of the program, strategy, project planning and development plan.
   - Responsible for creating and managing relationships with Advisory Boards, comprised of representatives from key TAY stakeholder groups within Los Angeles County, including TAY.
2. Establish a Fiscal Agent:
   - Financial oversight and governance of the project, maintenance of financial records, and collection and distribution of funds, according to the budget (to be established).
3. Create a Communications Team:
   - Develop communication with stakeholders on the progress of the project, with opportunities to provide input and become engaged in project planning.
4. Create a Technology Team:
   - Develop technology plans and timelines based on user requirements, to build, test and deploy the system in phases, based on agreements with the Project Leadership team.
5. Create Resource/Knowledge Teams:
   - Establish requirements for the types of resources needed by TAY, and collect and curate resources from County departments and local community-based organizations.
6. Create a Performance Management and Evaluation Team:
   - Identify performance metrics (data elements for specific outcomes) and

design evaluation and implementation metrics for tracking, analysis, and reporting.

Launch (9 to 12 months) and Roll-Out (9 to 18 months) Phases: Centralized TAY Hub Operational Team

In addition to the tasked described in items one through six above, the following will be needed for the launch (project piloting) and roll-out (full implementation) phases:

7. Create Content Curation Specialists:
   - Review, update, and curate content to ensure that all resources and knowledge are up-to-date, with content presented in easy to digest formats (through the use of multimedia, bilingual content, easy to understand language, etc.).

8. Create a Navigator Team:
   - Assist TAY, caregivers, County staff and other stakeholders with the usage of the system.

Leverage Current County Resources, Technologies and Funding Opportunities

The following have been identified as existing resources, programs and funding opportunities for moving forward with the Project Plan, in support of the implementation steps (presented above):

- Use of existing County department and/or private sector expertise to create the Centralized TAY Hub.
- Each County department can participate in the identification/curation of their TAY-specific programs, services, and knowledge.
- Leverage existing departmental technology and expertise as in-kind support for the Centralized TAY Hub concept.
- The vetting of the Centralized TAY Hub concept during the stakeholder forums has produced interest from several entities who are interested in serving as researchers and evaluators for the proposed concept.
- The County will continue to explore all available funding opportunities to plan, develop, and implement the Centralized TAY Hub concept.
- The CEO will continue to explore philanthropic funding opportunities (as identified in Section IV of this report), as will the Center for Strategic Public-Private Partnerships.

Proposed Next Steps

The following are the CEO's next steps to begin the work of creating the Centralized TAY Hub, upon the Board's acceptance of the report:

1. CEO will explore internal (County) and external (private sector, philanthropy, etc.) options to: (a) identify an entity with the expertise to realize the Centralized TAY Hub concept, as well as determine any agreements that will be required; and (b) evaluate external (non-County) options for funding the project.

2. CEO, with OCP and the full participation of relevant County departments in the proposed roles defined under the Prepare, Roll-Out and Implementation phases, will also implement a governance structure (i.e., Advisory Boards) that includes key internal and external stakeholders and advocates, to guide the implementation of the multi-year strategy.

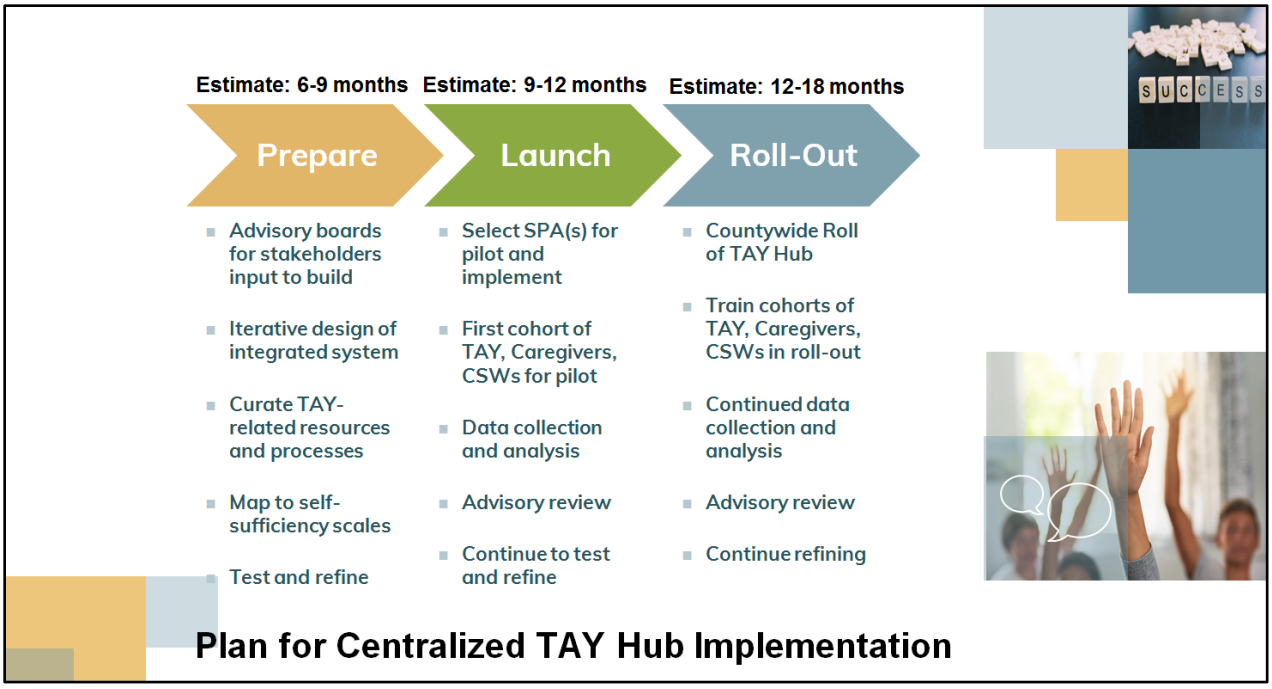
3. CEO will work directly with relevant Department Heads to develop Management Appraisal Performance Program (MAPP) goals directly related to fully supporting all Prepare, Roll-Out and Implementation phases of the Centralized TAY Hub, as outlined in the report.

Summary of TAY/TAY Related County Services and Supports

Department	Education	Health	Housing	Legal	Basic Living	Mental Health	Employment	Parenting	Referral Service	Total Funding for all Services
DCBA				•	•				•	N/A
DCFS	•	•	•	•	•	•	•	•	•	$36.4 M
DHS		•							•	Unavailable
DMH	•	•	•	•	•	•	•	•	•	$178.7 M
DPH		•	•	•	•	•	•		•	$19.6 M
DPSS	•	•	•		•	•	•		•	$21.9 M
LACOE	•	•	•	•	•	•	•	•	•	None TAY specific
LAHSA	•	•	•	•		•	•		•	$27.1 M
LIBRARY	•	•		•	•	•	•	•	•	$17.2 M
PARKS	•	•		•	•	•		•		$26.7 M
PROBATION		•	•	•			•	•	•	See DCFS
WDACS	•				•	•	•		•	$22.2 M

• **Includes the provision of substance use services**

Visual Display of Road Map for Operationalizing The Centralized Hub Concept



COUNTY OF LOS ANGELES
OFFICE OF CHILD PROTECTION

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JUDGE MICHAEL NASH (RET.)
EXECUTIVE DIRECTOR

August 20, 2018

To: Supervisor Sheila Kuehl, Chair
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Janice Hahn
Supervisor Kathryn Barger

From: Judge Michael Nash (Ret.)
Executive Director, Office of Child Protection

SUPPORTING PERMANENCY FOR FOSTER AND PROBATION YOUTH

On August 22, 2017, the Board passed a motion directing the Chief Executive Office (CEO), in conjunction with the Office of Child Protection (OCP), to coordinate with all relevant County departments—including the Health Agency (including Mental Health, Public Health, and Health Services); Public Social Services; Workforce Development, Aging and Community Services; the Los Angeles County Office of Education (LACOE); Probation; and Children and Family Services (DCFS)—and with input from key stake-holders (such as legal advocates, judicial officers, transition-age youth service providers, housing providers, educational program advocates and providers, workforce development programs, the philanthropic community, relevant commissions, and others) to coalesce existing efforts as a basis for a cohesive multi-year countywide strategy that will support the self-sufficiency goals of transition-age foster and probation youth at the earliest stage possible.

In reviewing existing efforts that would support the self-sufficiency goals of transition-age system youth at the earliest stage possible, we found work in three areas: first, preventing children from entering the child welfare/juvenile justice systems to begin with; second, finding permanency for youth so they don't face aging out of these systems without a permanent adult presence in their lives; and third, for TAY already in these systems, ensuring that services which could help them attain self-sufficiency and build resilience are available and easy to access.[1]

The CEO took the lead in ensuring that needed services for TAY were available and easy to access. With the Countywide prevention plan, *Paving the Road to Safety for Our Children: A Prevention Plan for Los Angeles County*, underway and working toward strengthening communities and preventing children from entering the child welfare/

[1] In this Board memo and in the attached *Permanency Plan for Los Angeles County Youth*, we use the term ***transition-age youth*** (or ***TAY***) to refer to young people already involved with DCFS or the Probation Department.

juvenile justice systems, the OCP focused on developing a plan to increase permanency for foster and probation youth, and in turn decrease the number of youth who age out of the system without permanency.

In developing this plan, the OCP engaged multiple stakeholders—including DCFS and Probation managers and workers, the Alliance for Children's Rights, Casey Family Programs, Children Law's Center Los Angeles, and Public Counsel—to conduct a review of research, best practices, and current County permanency efforts. The OCP also participated in focus groups (convened by the CEO) of youth, line staff, and relative caregivers to gain input and feedback on this report's recommendations. From this analysis, the OCP developed a plan to provide foster and probation youth with permanent adult connections to prevent them from aging out of the system alone. The OCP also participated in the TAY workgroup led by the CEO and helped engage philanthropy to identify projects, resources, and services in place for TAY.

If you have any questions, please contact me at (213) 893-1152 or by email at mnash@ocp.lacounty.gov, or your staff may contact Karen Herberts at (213) 893-2466 or by email at kherberts@ocp.lacounty.gov.

MN:CDM
KH:BBS:ae:oe:eih

c: Chief Executive Office
Executive Office, Board of Supervisors
Children and Family Services
Workforce Development, Aging and Community Services
County Counsel
County Library
Mental Health
Parks and Recreation
Probation
Public Health
Public Social Services
Los Angeles County Office of Education

Permanency Plan for Los Angeles County Youth

Los Angeles County

Office of Child Protection

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BACKGROUND

Foster care is supposed to be a temporary safe haven for children who have been abused or neglected, or whose parents can no longer provide adequate care. It was never intended as a permanent living arrangement. The majority of laws affecting child welfare also emphasize the temporary nature of foster care and specify provisions to improve permanency outcomes.[1]

- The Adoptions and Safe Families Act of 1997 (P.L. 105–89) requires states to begin court proceedings to terminate the parental rights for a child for adoption if that child has been in foster care for at least 15 of the last 22 months, except when such termination is not in the best interest of the child, or if the child is in the care of a relative.

  Among other items, this Act also: 1) allows for the concurrent planning of family reunification and other permanency options; 2) placed time limitations on reunification services provided through the Safe and Stable Families program (revised under the Child and Family Services Improvement and Innovation Act, passed on September 30, 2011); 3) emphasizes the importance of placing foster youth with adult relatives over non-related caregivers; and 4) mandates the documentation of efforts to find adoptive or other permanent placements for foster youth, including placements with fit and willing relatives.

- The Foster Care Independence Act of 1999 (P.L. 106–169) was designed to help prepare youth to transition from foster care to self-sufficiency, but also emphasizes permanence by indicating that independent living programs are *not* an alternative to adoption, and that permanent-placement efforts need to continue **concurrently** with independent living activities.

- The Fostering Connections to Success and Increasing Adoptions Act of 2008 requires all Title IV-E agencies to identify and notify all adult relatives of a child, within 30 days of a child's removal, of relatives' options to become placement resources for the child.

- The CAPTA Reauthorization Act of 2010 (P.L. 111–320) requires efforts to promote the adoption of older children, minority children, and children with special needs. It also requires the development and use of procedures to notify family and relatives when a child enters the child welfare system.

- The Child and Family Services Improvement and Innovations Act of 2011 (P.L. 112–34) requires each state plan to describe that state's activities to reduce the length of time children under five years of age are without a permanent family. It also modifies family reunification services to mandate services/activities like peer-to-peer mentor-

[1] Children's Bureau. (March 2015). "Major Federal Legislation Concerned with Child Protection, Child Welfare, and Adoption."

ing and support groups for parents and primary caregivers; it additionally facilitates visits between children and their parents and/or siblings.

- The Preventing Sex Trafficking and Strengthening Families Act of 2014 (P.L. 113–183) limits youth with Another Planned Permanent Living Arrangement (APPLA) plans to those age 16 or older; and preserves a child's eligibility for kinship guardianship assistance payments when a guardian is replaced by a successor guardian.

While federal law and County policies emphasize the temporary nature of foster care, for many of our youth, foster care has become a permanent arrangement—and our system has failed them.

THE IMPORTANCE OF PERMANENCY

Multiple research studies have demonstrated the importance of permanency and the need to address its challenges to improve outcomes for system youth. Youth who exit foster care without a permanent family or adult connection, for example, have a higher risk for many poor outcomes, including those involving teen pregnancy, poverty, homelessness, a lack of education, and involvement with the criminal justice system.

For most adults, the transition from childhood to adulthood is gradual, aided by a network of family members and social supports that guide the youth, often until the third decade of their life.[2] Various studies have found that a high level of social capital, or a support system upon which individuals draw to enhance their opportunities in life (e.g., a permanent family or connection), is a critical factor to their attaining higher education and developing positive self-worth. Furthermore, youth with less social capital have a greater risk of homelessness.[3] The presence of at least one caring adult who offers social support and connectedness is a protective factor for at-risk youth.[4] In fact, having at least one stable relationship with a committed, caring adult has been found to be the single most common factor in youth who develop resilience.[5]

Protective factors help build young people's knowledge, skills, and confidence, and further aid in their successful transition to adulthood, their overall resilience, and a recovery from the trauma that most foster youth experience.[6] Having a stable, permanent family and supportive community is linked with successful self-sufficiency, as involved individuals can help youth attain permanent housing, higher education, and emotional well-being.

While the average non-system teenager has social capital and supports to help them transition from childhood to adulthood, foster youth are often navigating life without

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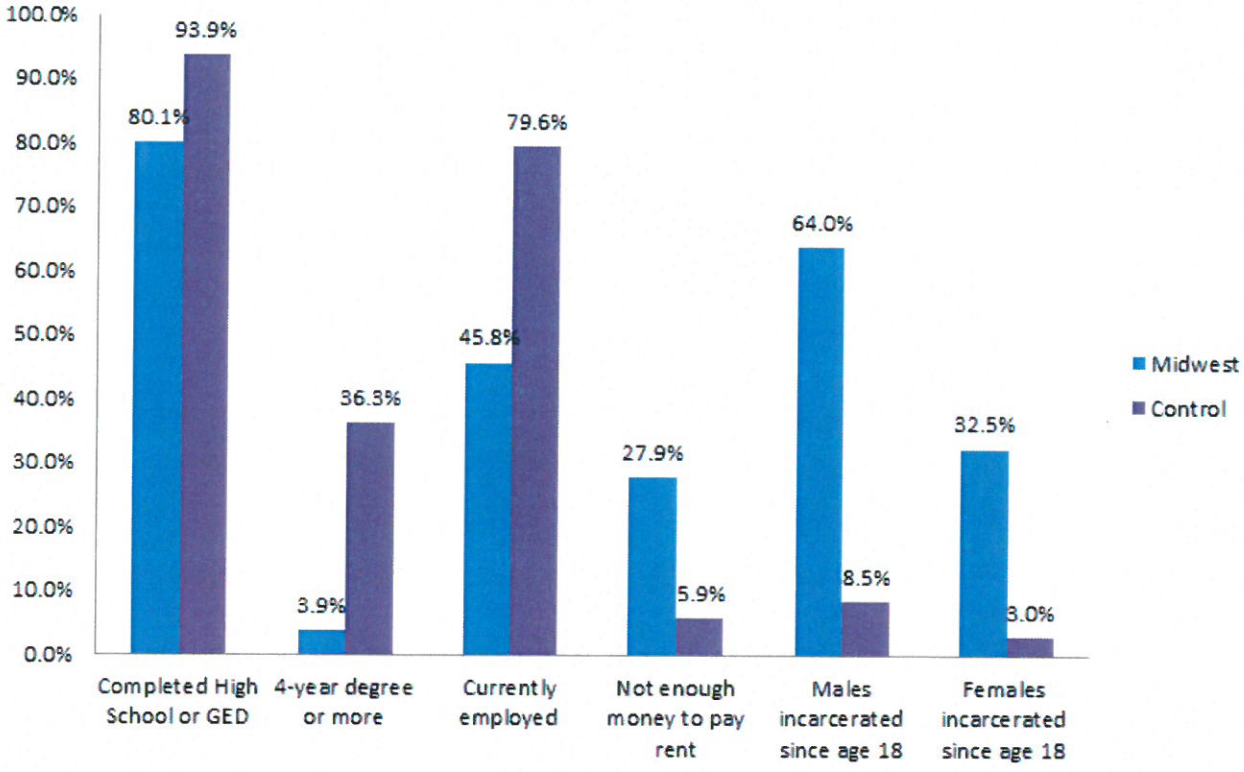
[2] Avery, R. (2009). An examination of theory and promising practice for achieving permanency for teens before they age out of foster care. *Children and Youth Services Review* 32 (2010) 399–408.
[3] Ibid.
[4] Ibid.
[5] Harvard University's Center on the Developing Child, 2016. https://ac.els-cdn.com/S0190740917308204/1-s2.0-S0190740917308204-main.pdf?_tid=0bcf4088-b6fe-4331-b64c-5cca982372c9&acdnat=1521147239_bc9bb4be74957ff2996b9a4277474e27
[6] Mallon, Aledort & Ferrera, 2002. https://www.ncbi.nlm.nih.gov/pubmed/12014475

these supports, in addition to transitioning out of care. A study from Chapin Hall at the University of Chicago compared foster youth who aged out of the system to similar-age youth from the general population, and Figure 1 illustrates some of the negative outcomes for foster youth who exit care without permanency.

The "Midwest Evaluation of Adult Functioning of Former Foster Youth: Outcomes at Age 26 (2011)[7]" was a longitudinal study of a cohort of foster youth who had aged out of the foster care system from three state child welfare agencies (Illinois, Iowa, and Wisconsin). Baseline survey data was collected from 732 foster youth at 17 to 18 years old, and the youth were re-interviewed at ages 19, 21, and 26.

Figure 1 shows that, at age 26, former foster youth who had aged out of the system were not doing as well as the general population at the same age. They had lower employment rates (46% vs. 80%), higher incarceration rates (males—64% vs. 9%), and fewer four-year college degrees (4% vs. 36%). In addition, approximately one-third (31%) of the foster youth participants reported couch-surfing or being homeless for at least one night in the previous 27 months, and over one-third (38%) worried about running out of food.

Figure 1. Midwest Evaluation



These studies illustrate the importance and benefits of permanency, along with the consequences of foster youths' not achieving it. It is imperative that Los Angeles County implement a practice model that prioritizes both permanency and self-sufficiency to prevent youth from aging out of the foster care system without permanency.

[7] Courtney, M., Dworsky, A., Brown, A., Cary, C., Love, K., Vorhies, V. (2011). "Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 26." Chapin Hall at the University of Chicago.

PERMANENCY DEFINED

Through the Adoption and Safe Families Act of 1997, federal law established a hierarchy of permanency goals to be pursued: 1) reunification, 2) adoption, 3) guardianship, 4) placement with a fit and willing relative, and 5) another planned permanent living arrangement (APPLA), formerly known as long-term foster care.

For the purposes of this report, permanency is defined as:

- Legal permanency through reunification, adoption, or legal guardianship
- Placement with a fit and willing relative
- Emotional permanency, or a safe emotional relationship between a youth and caring adult (family or non-family member) who will offer mentorship and support to the youth (for example, by providing a place to visit during the holidays, housing, moral support, etc.) throughout his or her life

Out of these permanency options, only reunification and adoption presume that the adult will stay in the child's life for a lifetime. Options such as emotional permanency may be more important to some youth, however,[8] and can also improve a variety of outcomes, including educational attainment, living situation, emotional well-being, interpersonal relationships, and coping.[9]

Youth Voice on Permanency

Through forums conducted with former foster youth, the OCP collected a variety of comments on how they would like permanency to be achieved in their lives. For these youth, the most important element is having stable and caring adults throughout their lives to provide guidance and support when needed.

Many youth in the TAY forums indicated that they had not previously experienced legal permanency in their lives, but several listed family members, advocates, social workers, and other adults as their permanent connections. When asked how important a permanent adult connection is for them, several TAY stated that they wanted mentors to help them find careers, educational opportunities, and housing, and to connect with when times get tough.

Youth also wanted to be integrally included in their permanency process. They want the system to focus on permanency solutions that are not "cookie cutter" and that take into account youths' individual needs when finding placements and resources for them.

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[8] Sanchez, R.M. (2004). *Youth Perspective on Permanency*. California Permanency for Youth Project. http://www.ocfcpacourts.us/assets/files/list-778/file-1026.pdf.

[9] Ahrens, K. R., Lane DuBois, D., Garrison, M., Spencer, R., Richardson, L. P., & Lozano, P. (2011). Qualitative exploration of relationships with important non-parental adults in the lives of youth in foster care. *Children and Youth Services Review*, 33, 1012–1023. doi:10.1016/j. childyouth.2011.01.006; Child Welfare Information Gateway (May 2013). Enhancing Permanency for Youth in Out-of-Home Care. https://www.childwelfare.gov/pubs/focus/enhancing/.

LOCAL PERMANENCY DATA

Los Angeles County operates one of the largest child welfare agencies in the nation. In 2017, it received an average of over 18,600 child welfare hotline calls a month, with approximately 30% of those calls resulting in an investigation. As of April 2018, over 34,000 youth were receiving child welfare services, of whom over 10,000 received family reunification services and over 10,000 were eligible for a permanent placement with an adult other than their parent. Approximately 18,000 of these youth were in out-of-home placement, with an additional 1,124 youth in adoptive homes and 1,543 youth in a guardian's home.

As of May 30, 2018, 493 probation youth were in residential foster care, with an additional 27 living with a relative or non-relative under a suitable-placement order.

Because the County touches the lives of so many children and families through its foster and probation systems, permanency must become a top priority.

DCFS Data

County data illustrates that for many of our youth, foster care is not a temporary intervention. Youth are staying in the system for multiple years, and numerous youth are not achieving legal permanency before they exit care.

Length of Time in the Child Welfare System

Table 1 reflects point-in-time data in 2016 for 16-, 17-, and 18-year-olds in the child welfare system.[10]

Table 1. The Age the Youth Entered the Child Welfare System

Point-in-Time Report: 2016	Age the 16-year-old entered system		Age the 17-year-old entered system		Age the 18-year-old entered system	
Age	n	%	n	%	n	%
Ages 0–5 years	108	7.3%	118	7.8%	124	12.5%
Ages 6–10 years	188	12.7%	148	9.8%	115	11.6%
Age 11	56	3.8%	57	3.8%	49	4.9%
Age 12	85	5.7%	76	5.0%	56	5.7%
Age 13	132	8.9%	106	7.0%	80	8.1%
Age 14	212	14.3%	146	9.7%	98	9.9%
Age 15	452	30.4%	242	16.1%	131	13.2%
Age 16	252	17.0%	412	27.4%	168	17.0%
Age 17			201	13.3%	160	16.1%
Age 18					10	1.0%
Total	**1,485**	**100.0%**	**1,506**	**100.0%**	**991**	**100.0%**

Note: Data source is from CWS/CMS data warehouse.

[10] Data courtesy of DCFS Business Information Systems.

As shown, the majority of these youth have been in the system for multiple years. Almost a quarter (24%) of 18-year-olds entered the child welfare system at age 10 or younger, as did one in five (19.9%) 16-year-olds. A large number of youth entered the child welfare system as teenagers, as well, with over 30% of 16-year-olds entering at age 15, and over 27% of 17-year-olds entering at age 16. One in three of those youth (34% and 35%, respectively) were re-entries into the child welfare system.

These data are consistent with findings from the National Center for Youth Law's report *Promoting Permanency for Teens: A 50 State Review of Law and Policy,*[11] which indicated that for this age group, "much of the policy and programmatic focus is not on permanence, but on independence. Teens need both."[12]

Additionally, the study "There's no place like home: achieving safety, permanency, and well-being for lesbian and gay adolescents in out-of-home care settings"[13] found that only 8% of respondents were in fact adopted at some point in their lives. That study went on to state, "However, more than one-third (34%) of the youth surveyed indicated that, if they could be adopted, they would like to be adopted." Although adoption may not be what all older youth want, it needs to be actively promoted as a desirable permanency option for older youth.

For foster youth aging out of the system, the average length of time spent in care has fallen since 2012, when 148 21-year-olds aged out after spending an average of over 10.5 years in the system. But we still need to do better. In 2016, 520 21-year-olds exited without legal permanency, having spent an average of 7.75 years in care (Table 2).[14]

Table 2. Number of Youth Aging out of Foster Care and Their Average Days in Care

	2016		2015		2014		2013		2012	
Age	# of youth	Avg time	# of youth	Avg time	# of youth	Avg time	# of youth	Avg time	# of youth	Avg time
Under 18	6	376	4	1,042	10	612	11	1,229	11	682
18	241	1,622	241	1,543	206	1,307	263	1,697	277	1,754
19	116	1,852	148	2,433	180	2,086	217	2,112	286	2,514
20	57	2,076	57	2,461	84	2,790	93	2,710	199	3,176
21	520	2,831	522	3,133	348	3,374	167	3,759	148	3,864
Over 21	8	2,778	5	4,612	4	2,878	7	4,727	9	4,078

CWS/CMS Datamart as of 12/27/2017

Permanency

According to point-in-time data received from DCFS for 2012 through 2016, approximately 9,000 children/youth every year had case plans calling for Permanent Placement. A plan of Permanent Placement means that efforts to reunify the family (if any)

[11] Johnson, A., Speiglman, R., Mauldon, J., Grimm, B., Perry, M. (February 2018) *Promoting Permanency for Teens, A 50 State Review of Law and Policy*. National Center for Youth Law.
[12] Ibid.
[13] Mallon, Aledort & Ferrera. (2002). There's no place like home: achieving safety, permanency, and well-being for lesbian and gay adolescents in out-of-home care settings. *Child Welfare*. Mar–Apr;81(2):407–39.
[14] Data courtesy of DCFS Business Information Systems.

have ended, and identifying a permanent home for these youth no longer involves returning to their biological parent's home.

DCFS data for 2016 (Table 3), shows that 1,171 (12%) of the 9,298 youth with a Permanent Placement case plan were placed into Another Planned Permanent Living Arrangement (APPLA), formerly known as long-term foster care. Of those APPLA youth, 935 (80%) were placed with non-relatives, and 504 (43%) were under 16 years of age. The remaining 8,127 children/youth, with an average age of 8.77 years, were available for adoption or other legal permanency options.

Table 3. Youth Available for a Permanent Placement (Not With Original Parent) and Those Youth in APPLA

Age	2016			
	Permanent Placement	APPLA with non-relative	APPLA with relative	Total APPLA
0	156			-
1	535		1	1
2	622	2	1	3
3	610	3	5	8
4	504	1	4	5
5	469	2	5	7
6	466	6	5	11
7	399	2	6	8
8	432	11	8	19
9	444	12	7	19
10	434	24	6	30
11	422	24	8	32
12	395	32	12	44
13	432	51	13	64
14	465	84	13	97
15	541	131	30	161
16	611	190	31	221
17	747	265	60	325
18	429	78	17	95
19	137	11	4	15
20	45	5		5
21	3	1		1
Total:	**9,298**	**935**	**236**	**1,171**

1. Data source is CWS/CMS data warehouse

2. APPLA pop. based on Service Compt = PP

APPLA does not achieve legal permanency, and it lasts only while a youth has an open case in dependency court. The Preventing Sex Trafficking and Strengthening Families Act of 2014 stipulates that an APPLA plan must be used only for youth 16 years of age or older.[15] This federal law was incorporated into California state law on October 1, 2015, with state guidance released in April 2016.[16] When a youth has an APPLA permanency plan, the case plan must include "ongoing and intensive efforts to return home, adoption, tribal customary adoption, legal guardianship, or placement with a fit and willing relative, as appropriate."[17] APPLA plans for children younger than age 16 should be inspected to ensure their compliance with this law, and placements with non-relatives should be reviewed to determine if a more formalized permanency plan can better address the youth's needs.

Table 4 shows the number of exits from DCFS over the past five years. Although the number of finalized adoptions increased over the last four years—from 1,370 (14.1%) in 2014 to 1,585 (17.3%) in 2017—the overall percentage of youth who exited care in 2017 with legal permanency (88.15%) was the lowest in those five years, and 11.85% of our youth (1,084 individuals) aged out of the system without those permanent supports.

[15] Preventing Sex Trafficking and Strengthening Families Act of 2014 (PL 113–183). The provisions of this Act were signed into California law on October 1, 2015, through Senate Bill 794 (Chapter 425, Statutes of 2015).

[16] California Department of Social Services All County Letter No. 16-28, Another Planned Permanent Living Arrangement. http://www.cdss.ca.gov/Portals/9/lettersnotices/ACL/2016/16-28.pdf?ver=2016-04-26-130918-000

[17] Ibid.

Table 4. Exit Statistics
Children Exiting Foster Care through Reunification, Adoption, Guardianship, or Aging Out

	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017
Number family reunifications	5,922	6,372	5,749	5,769	5,404
Number finalized adoptions	1,308	1,370	1,439	1,532	1,585
Number of children with guardianship granted	1,059	1,077	1,196	1,212	1,076
Legal Permanency Subtotal	8,289	8,819	8,384	8,513	8,065
Legal Permanency Percentage	92.03%	90.77%	88.20%	88.82%	88.15%
Number of exits per year of youth 18 and over	718	897	1,122	1,072	1,084
Total Exits	9,007	9,716	9,506	9,585	9,149

1. Data source is CWS/CMS Datamart as of 7/8/2018.

2. Table includes all cases.

Over the past five years, 4,893 youth have exited our foster system without permanency. Based on 2016 data from Table 2, we can extrapolate that these youth have spent multiple years in the system and, as shown earlier, are at a higher risk of experiencing many negative outcomes after leaving care.

Probation Data

The Probation Department's Placement Permanency and Quality Assurance (PPQA) unit works with Probation foster youth—wards of the delinquency court who are mainly under Probation's jurisdiction—to help them achieve permanency. As of May 2018, the PPQA had 47 active permanency cases out of the 103 dual-system cases for which Probation was the lead agency (45% of cases). Of these 47 active permanency cases, three youth had re-entered the foster system at least once.

Table 5 illustrates the service breakdown, and Table 6 provides the length of time the 47 youth have been in the system by age.

Table 5. Probation Foster Youth
Permanency Services

Type of Permanency Service	# of youth	% of youth
Family Reunification	17	36.1%[1]
Family Finding	9	19.1%
APPLA	14	29.7%
Legal Guardianships	5	10.6%[1]
Adoptions	2	4.3%
Total	47	100%

Table 6. Number of Probation Foster Youth by Time in Care and Age

Time in Care	13 yrs old	14 yrs old	15 yrs old	16 yrs old	17 yrs old	18 yrs old	Total
	n	n	n	n	n	n	
0–6 months	0	1	2	4	3	0	10
6–12 months	0	0	2	7	8	0	17
12–18 months	0	0	1	4	2	1	8
18–24 months	1	0	0	1	2	0	4
24+ months	0	1	1	1	4	1	8
Total	1	2	6	17	19	2	47

As shown, youth ages 16 and 17 make up the bulk of PPQA's permanency cases. While a large percentage are working toward reunification with their families, the next highest permanency exit outcome is APPLA, or long-term foster care.

Two issues warrant further review: 1) to determine if other permanency services or assistance should be provided to the remaining 56 youth for whom Probation is the lead agency; and 2) to ask that Probation review APPLA cases to see if a more formalized permanency plan can better meet the needs of these youth.

What the Data Tell Us

As of December 31, 2017, over 2,200 youth in the child welfare system had not yet achieved permanency; the majority (1,942 youth) were in extended foster care (Table 7).

Table 7. Foster Youth 18 and Older with No Permanency

	Year End 12/31/2017
Number of youth 18 years and over not in AB12 extended foster care	328
Number of children 18 years and over in AB12 extended foster care	1,942
Total	2,270

1. Data source is CWS/CMS Data Warehouse.

2. Table only includes court cases.

3. Data reflect year-end child population with active cases.

4. Children 18 years and over in ext. foster care (based on out-of-home placement rec.)

In addition, exit data from 2013 through 2017 show that family reunifications declined from a high of 6,372 (66%) to 5,404 (59%) during that time period. Approximately 4,900 youth 18 and over exited the system expecting to face adulthood without the social connections and stability that permanency can provide young adults (Table 4).

Collectively, these data demonstrate that our youth are staying in the system far too long, and that 12% are exiting the system without permanency after spending a quarter to a third of their lives in care. This is unacceptable. We must urgently address this issue to improve the future trajectory of youth in our care.

CURRENT PERMANENCY EFFORTS

Several efforts and programs are underway throughout the County to help increase permanency outcomes for foster youth.

Concurrent Planning

Concurrent planning is a case-management method used to support legal permanence (family reunification, adoption, or legal guardianship) within a specific timeframe. It emphasizes the initiation and/or completion of permanency tasks as soon as a child enters placement to resolve a child's temporary status. Concurrent planning focuses on achieving family reunification as the primary permanency option for a child (plan A). The alternative permanency option (plan B) is established at the time of the Welfare & Institutions Code (WIC) 366.21e hearing so option of adoption or legal guardianship is left in place for the child. The Concurrent Planning Assessment (CPA) tool is used to develop plan B and identifies the alternate permanent plan and prospective resource/ adoptive family.

Resource Family Approval

Resource Family Approval (RFA) allows for all out-of-home placements to be approved for adoptive placement and legal guardianship as well as for temporary foster care placement. All families go through the same RFA assessment process so foster parents as well as relatives can be ready to proceed with alternative permanency options if family reunification efforts are unsuccessful.

Permanency Outreach Around Foster Youth

DCFS has some significant media-based campaigns, such as Wednesday's Child, Heart Gallery, and KidSave, to help recruit families for older youth who have not yet been matched with adoptive families.

Probation has conducted several media campaigns and child-centered efforts to provide probation foster youth with permanency. While it has had some successes—and the most probation foster youth adoptions in the country—it still struggles to recruit families for this population. To further enhance permanency options for probation/child welfare youth, Probation has contracted for a holistic marketing campaign of multiple channels (digital, media, television, mail, radio, and more) offering a variety of avenues to reach county residents within the targeted audiences. The campaign strategy has a unique data-informed/data-driven approach, its design supports the goals of both Probation and DCFS, and it is intended to support a single-portal entry system for the County of Los Angeles in the future.

Mentoring Programs for Parents

The Parents in Partnership (PIP) program began in 2006 with a grant from the Annie E. Casey Foundation. PIP utilizes parent mentors who have successfully reunified with their children to guide families with children in foster care—especially those who have recently lost custody—through their rights and responsibilities. A 2017 preliminary study published in the *Journal of Social Service Research* found that parents who attended a

PIP orientation were five times more likely to reunify with their children that those who did not. While the initial study was limited in size, it highlights PIP as a promising intervention.[18]

Youth Permanency Units (YPUs)

Two DCFS regional offices have youth permanency units (Santa Clarita and Pomona), where six caseworkers each serve 15 youth on their caseloads. These units focus on finding and engaging family members and non-relative extended family members to provide permanent, lifelong family connections to older youth in long-term care. They also work with the youth at developing at least one durable connection with a committed adult through existing relationships or through mentoring programs before the youth exits the system. This unit conducts family-finding for youth age 11 and up, and connects youth to an educational mentoring program that stays with them until they are 21. This unit does not currently track data, but a 2009 report by Casey Family Programs[19] did track these units, then in the Metro North and Pomona regional offices. Collectively, the YPUs served 147 youth, connecting approximately 73% to family members where no connections had previously existed. Although this was an initial positive outcome, without consistent data collection it is difficult to tell now what progress the YPUs have made.

Upfront Family-Finding Pilot

In November 2016, the OCP developed and implemented an upfront family-finding pilot in the Glendora and Santa Fe Springs DCFS offices. This pilot utilized existing DCFS Permanency Partners Program (P3) social workers to bring family-finding efforts to the front end of the system. As of August 2017, placement rates with relatives and non-related extended family members had increased from 59% to 82% in Santa Fe Springs and from 58% to 75% in Glendora during the pilot months of October 2016 through May 2017, growing by over 20% in both offices. The pilot was recently expanded to Vermont Corridor and West Los Angeles.

While this work has a potential impact on permanency efforts, it is too soon yet to determine whether finding family members will improve permanency outcomes for youth. However, a report by DCFS in 2010 on the P3 Upfront Family-Finding and Engagement Plan-Do-Study-Act pilot found that for youth in the treatment group of the pilot, family-finding efforts doubled the number of connections for youth, greatly increased identified parental relatives (30 new parental relatives, as opposed to the control group's three), and increased the rate at which these youth were reunified with their families.

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[18] Enano, S., Freisthler, B., Perez-Johnson, D., Lovato-Hermann, K. (2017) Evaluating Parents in Partnership: a Preliminary Study of a Child Welfare Intervention Designed to Increase Reunification. *Journal of Social Service Research*, 43:2, 236–245, doi: 10.1080/01488376.2016.1253634

[19] Casey Family Programs (2009). Stories of Practice Change: What flexible funding means to the children and families of Los Angeles County. https://www.shieldsforfamilies.org/download/art_0902_01.pdf

Permanency Child and Family Teams

Permanency Child and Family Teams (PCFTs) and permanency-values training for DCFS workers, done through a partnership with Casey Family Programs, are additional promising practices. PCFTs meet every 30 days (more frequently than the typical CFT) for an intensive review of a child's entire case plan, from system-entry on, to find relatives or other permanent connections. Over 18 months, Casey Family Programs examined over 125 cases across the Van Nuys, Compton, Lancaster, Belvedere, and Pasadena DCFS offices. PCFTs target youth who have been in the system for two or more years, starting with those as young as nine. While this process can be time-consuming, it has allowed several youth to find previously unexplored connections and achieve permanency. An evaluation of this work will be released by Casey Family Programs at a future date.

Permanency for Older Youth

DCFS and Probation have both focused on achieving permanency for older youth through non-minor dependent adoptions, in which Los Angeles County is currently a leader. This work has been driven by the Alliance for Children's Rights and DCFS, in partnership with the juvenile court, and has helped 23 non-minor dependents be adopted since 2013.

While many youth and caregivers believe that they lose out on Independent Living Program (ILP) benefits if youth are adopted, they are actually entitled to ILP benefits as well as Adoption Assistance Payments (AAP) up to age 21, if they are adopted at age 16 or older. Likewise, youth in relative guardianships qualify for Kinship Guardianship Assistance Payments (Kin-GAP) until age 21, if the guardianship was established when the youth was age 16 or older. Youth in guardianships with non-relatives qualify for state foster care benefits.

Non-minor dependent adoptions are especially useful as they provide older youth, who may understand more of what they want, another opportunity for permanent adult connections.

Mentorship Programs for Youth

Mentorship programs through nonprofit, faith-based, and philanthropic entities can be an option for youth. A recent mentoring summit explored best practices and emerging innovative models with the goal of coordinating and expanding trusted mentoring programs throughout Los Angeles County. When mentoring matches a long-term caring adult with a youth, it can build social connections and provide concrete supports in times of need—two protective factors that are critical to effectively enhancing child development.

Research shows that up to 70% of youth exiting from care who had long-term mentorships gained important informational advice, emotional support, and enhanced social skills, with those relationships helping to keep the youth on a track to prevent negative outcomes and in turn provide support to achieve positive outcomes.[20] However, the

[20] http://nationalmentoringresourcecenter.org/images/PDF/Mentoring_for_Youth_in_Foster_Care_Population_Review.pdf

CalYOUTH Study by Chapin Hall at the University of Chicago indicated that "L.A. County youth had fewer people to turn to for social support, particularly when they needed tangible support or advice and guidance."[21]

As discussed earlier, youth in the TAY focus groups wanted and believed in the importance of having a permanent adult connection. While legal permanency should always be pursued first, emotional permanency is also important to consider and prioritize for foster youth.

BARRIERS TO PERMANENCY

The following barriers outline the themes that we heard or found in our analysis of permanency efforts within the County.

Lack of Local Data on Foster-Youth Outcomes Once They Exit the System

While DCFS tracks data concerning youth currently in care, little to no data is available on how youth fare after they exit the system, either through legal permanency or through aging out. No mechanism exists, either, to track the number of adoptions or legal guardianships that dissolve. Additionally, several programs with permanency components do not collect data, making it difficult to determine which promising programs should be leveraged and/or expanded.

Lack of Urgency on Permanency

When it comes to permanency for Los Angeles County's foster youth, the numbers are troubling. A large number of youth stay in the system for years without achieving permanency, and adoption rates for the County—despite a greater than 3% increase from 2014 to 2017, for a 17.3% rate—are lower than they are for the state as a whole, at 24.0% (6,679 adoptions out of 27,748 foster youth) for 2017.[22] Although the foster system emphasizes the need for child safety, permanency, and well-being, the focus is most often on the youth's most important and immediate problems—often safety and well-being. As a result, concurrent planning and the timely submission of the CPA concurrent-planning tool often take a lower priority.

Furthermore, with the additional workload that the Resource Family Approval (RFA) process has brought to DCFS, current permanency efforts have mostly focused on RFAs and have negatively affected the amount of time adoptions-unit children's social workers are able to spend on adoptions and other permanency options.

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[21] Courtney, M.E., Okpych, N.J., Charles, P., Mikell, D., Stevenson, B., Park, K., Kindle, B., Harty, J., Feng, H. (2016). *Findings from the California Youth Transitions to Adulthood Study (CalYOUTH): Conditions of foster youth at age 19*. Chicago, IL: Chapin Hall at the University of Chicago.

[22] Webster, D., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Putnam-Hornstein, E., Wiegmann, W., Saika, G., Eyre, M., Chambers, J., Min, S., Randhawa, P., Sandoval, A., Yee, H., Tran, M., Benton, C., White, J., Lee, H. (2018). CCWIP reports. Retrieved 7/31/2018, from University of California at Berkeley California Child Welfare Indicators Project website. http://cssr.berkeley.edu/ucb_childwelfare

Placement Instability

Youth cited placement instability as a significant barrier to achieving permanency, particularly with respect to a DCFS policy that outlines the grievance-review process following the receipt of a seven-day written notice of intent to remove a child from a foster home.[23] A few youth spoke of instances where they were "seven-dayed" for reasons such as changing schools or misbehaving. The youth were frustrated that there was no meeting to sit down and discuss grievances and try to work out issues before a placement was terminated. Although some divisions hold CFTs prior to youth being moved, this seems not to be standard practice. DCFS policy appears to be silent as to the youth's involvement during efforts to resolve disagreements leading to removals, which misses an important opportunity to potentially stabilize placements.

According to the California Child Welfare Indicators Project,[24] the average number of placement moves in Los Angeles County increases as youth get older (Table 8). These figures reflect an average number of moves, which means, of course, that some youth experience more. Although the County had fewer placement moves than those reported by the state as a whole (2.91 vs. 3.76), it has not achieved its goal of "first placement being last placement."

Table 8. Placement Stability in Los Angeles County
Children Who Entered Foster Care During a 12-Month Period

Age Group	Foster-Care Days for Children with Entries	Placement Moves	Per 1,000 Days
Under 1	322,883	632	1.96
1–2	208,858	586	2.81
3–5	244,029	694	2.84
6–10	328,113	1,008	3.07
11–15	245,713	934	3.80
16–17	74,359	285	3.83
Total	1,423,955	4,139	2.91

Data Source: CWS/CMS 2017 Quarter 4 Extract.

[23] http://policy.dcfs.lacounty.gov/Content/Grievance_Review_Regardi.htm
[24] Webster, et al. California Child Welfare Indicators Project, University of California at Berkeley

Placement Distance

Placement distance, coupled with the difficulty of coordinating transportation in Los Angeles County, may hinder visitation efforts while reunification services are being provided.[25] In fact, research has found that children placed closer to their birth homes are more likely to reunify than children placed farther away.[26] Table 9 shows the average distance children are is placed from their original home of parent, broken out by DCFS regional office. These distances range between 20 to 30 miles, which in Los Angeles means a minimum of one hour or more travel time. While a closer placement may not always be the most appropriate setting, distance is important to consider; in addition to affecting reunification efforts, longer distances also disrupt a child's education and may remove them from supportive family and community resources.

Table 9. Distance from Home of Parent to Placement Location

DCFS Office	Avg Distance
Belvedere	20.46
Compton	22.67
El Monte	27.80
Glendora	28.94
Lancaster	30.34
Metro North	26.21
Palmdale	27.78
Pasadena	27.67
Pomona	27.19
Santa Clarita	28.41
Santa Fe Springs	20.73
South County	25.49
Torrance	22.67
Van Nuys	23.91
Vermont Corridor	23.45
Wateridge North	25.78
Wateridge South	24.41
West Los Angeles	24.74
West San Fernando Valley	24.08

1. Data source is CWS/CMS data warehouse
2. Avg Distance is an avg driving distance
3. Avg Distance excld placemts over 500 mi

Concern around Continued Eligibility for Benefits

The relative caregivers the OCP interviewed were a mixture of those who had adopted and those who provided foster care, APPLA, and legal guardianship. Adoptive caregivers indicated that, in the past, adoption was the only option they were given, that the process created tension between them and the biological parents, and that adoption also terminated access to services and benefits for the children. The caregivers were committed to the children in their care, but were concerned about possibly losing access to benefits and services, especially benefits available for higher education and services for developmental and mental health issues. The OCP attempted to compile the various benefits for foster and probation youth, including their eligibility requirements, and found it challenging to fully understand what is available.

Lack of Comprehensive Post-Permanency Services

The DCFS post-adoption unit provides time-limited services to families with finalized adoptions, but no services were identified to help stabilize other permanency exits.

[25] http://www.lao.ca.gov/reports/2013/ssrv/child-neglect/child-neglect-080813.pdf
[26] Freundlich, M., & Avery, R. J. (2005). Planning for permanency for youth in congregate care. *Children and Youth Services Review*, 27, 115–134.; Lery, B., Webster, D, Chow, J. (2004). "Far from Home: The Effect of Geographic Distance on the Likelihood of Reunification for Children in Foster Care." Paper presented at the Association for Public Policy Analysis and Management Fall Research Conference, Atlanta, GA, October 28–30.

Multiple and Uncoordinated Efforts Around Permanency in the Public and Private Sectors

As discussed previously, several permanency efforts are occurring within the County, such as DCFS' Youth Permanency Units and upfront family-finding pilots, as well as the work of Casey Family Programs, the Alliance for Children's Rights, and others. However, these programs do not coordinate across the DCFS regional offices, and initiatives may not be aware of the other permanency resources available.

Permanency Difficulties Around Specialized Foster Youth Populations

Probation foster youth, youth with mental health needs, and lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth often have poorer permanency outcomes compared to other foster youth. They are harder to find permanent homes for, and are often not placed in family settings. For example, LGBTQ youth are twice as likely to live in group homes than family placements,[27] and foster youth with mental health needs are less likely to exit care to reunification or adoption than their undiagnosed counterparts.[28]

Lack of Youth Voice in Permanency Planning

Youth want more involvement in their care planning. Survey results have found, and youth participating in our forums confirmed, that foster youth typically have little to no involvement when decisions are made about their short- or long-term care plans.[29]

FISCAL IMPACT OF LEGAL PERMANENCY

The Jim Casey Youth Initiative estimates that an average of $300,000 is paid in social costs over the lifetime of every young person who ages out of the child welfare system.[30] Permanency not only improves youth outcomes, it may also provide significant cost savings for the County that could be reinvested in other youth services. When youth leave the child welfare system alone, they often require services to address homelessness, substance abuse, early pregnancy, or unemployment. By investing early in child-centered specialized permanency services, the County can improve permanency outcomes for all youth and reduce the social costs that follow. Table 10 outlines the potential savings for the County of Los Angeles[31] based on a report by Families Now[32] that analyzed permanency savings across California counties.

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[27] Sexual and Gender Minority Youth in Foster Care: Assessing Disproportionality and Disparities in Los Angeles. https://williamsinstitute.law.ucla.edu/wp-content/uploads/LAFYS_report_final-aug-2014.pdf

[28] Howard, J. & Berzin, S. (2011). "Never too old: Achieving permanency and sustaining connections for older youth in foster care." *Policy and Practice Perspective*. New York, NY: Evan B. Donaldson Adoption Institute.

[29] Unrau, Y.A. (2006). Research on placement moves: Seeking the perspective of foster children. *Children and Youth Services Review*, 29(1), 122−137.

[30] Thompson, A.E. & Greeson, J.KP. (2015). Legal and Relational Permanence in Older Foster Care Youth. *Social Work Today.* July/Aug. Issue Vol. 15 No. 4.

[31] This report lists savings based on a non-IV-E waiver county, in anticipation of the Title IV-E waiver's ending in 2019.

[32] Families Now. (2015). Funding Youth Permanency. https://www.sierrahealth.org/assets/Funding_Youth_Permanency_Guide_June_2015.pdf

Table 10. Permanency Savings

Permanent Placement Type	Previous Placement	Total County Controlled Savings
Adoption	Group Home Level 14	$74,198
	Foster Family Agency	$10,856
	Licensed Foster Home	$1,671
Kin Guardianship	Group Home Level 12	$67,582
	Foster Family Agency	$11,821
	Licensed Foster Home	$2.095
Second Chance Reunification	Group Home Level 10	$62,772
	Foster Family Agency	$15,770
	Licensed Foster Home	$6,584

As shown, the potential saving to the County for achieving permanency is significant, and these savings would accrue each year a youth would have been in care. For example, if a youth placed in a foster family agency is adopted at age 16, the County could potentially save a total of $54,280, assuming the youth would have stayed in care until the age of 21. If this same youth were adopted at age 13, the County could potentially save $86,848.

To achieve permanency, an investment in front-end specialized permanency services is often needed. A one-time cost of these services can range from $12,000 to $15,000. In the above example, assuming the youth received the most expensive specialized permanency services in California, the savings to the County would potentially be a total of $39,280 if the youth were adopted at age 16, and $71,848 if the youth were adopted at age 13.

These savings do not consider any services provided once youth enter legal permanent relationships, such as post-adoptive services or mental health treatment. However, these savings do take into account Adoption Assistance Payments (AAP).

PLAN TO INCREASE PERMANENCY FOR FOSTER YOUTH

In 2011, DCFS released "A Guide to Permanency Options for Youth," which included a call to action to ensure that the child welfare system does not become, by default, the "parent" of the children it protects. It is time to refocus and prioritize permanency to be just as important as the safety and well-being of foster youth.

Permanency is a process that can be achieved only through continual child-centered efforts to understand what permanency for each individual youth looks like, and by

helping the youth understand what options are available. As the youth in our forums reminded us, not all youth need the same thing.

The goal is to ensure that all foster youth achieve some form of permanency—legal or emotional. While legal permanency is preferred, the child welfare system should ensure that youth have at least one secure long-term adult connection as soon as possible after they enter the system, and help to strengthen their personal network before they exit care.

We don't profess to know it all, but we believe these areas warrant further exploration.

Expand Current Permanency Efforts

These programs appear to be making an impact on permanency, and expanding them should be considered.

- Upfront Family-Finding With the initial success of this pilot, as well as the success of the program in its current back-end position, it is recommended that the program be expanded and the number of P3 workers on the back end increased to help locate/identify potential permanent connections for both younger and older youth in the system.

- Mentoring Programs for Parents Given the positive outcomes from the PIP program, it is recommended that more resources and attention be given to this effort to help improve reunification efforts for our families.

- Mentoring Programs for Youth Although limited outcome data are available on the referral of system youth to these programs, multiple studies have shown the benefits of long-term mentoring programs. In addition, as mentioned previously, the youth who participated in our forums expressed their desire for mentors—especially those whose interests align with theirs. Before youth exit care, workers should facilitate connections with long-term caring and trusted adults to provide support and guidance in moments of crisis to help youth achieve emotional permanency. These permanent adult connections may include the youth's social worker, but they also need to include other dedicated adults.

- Non-Minor Dependent Adoptions Several of the youth and workers from our focus groups were not aware of the option for non-minor dependent adoptions. Perhaps the Alliance for Children's Rights could partner with DCFS to provide training on non-minor dependent adoptions. There needs to be more emphasis on this program option, as the search for permanency should never end.

In addition, outcomes for the following programs should be monitored to determine if they should be expanded:

- Youth Permanency Units
- Permanency Child and Family Teams

Increase Post-Permanency Services

The DCFS post-adoption services unit should conduct a review of its services, with caregiver input and data about dissolved permanent placements, to determine whether the services provided meet the needs of the families. DCFS should also explore what services can be leveraged with programs such as the Prevention & Aftercare (P&A) networks, and whether the ability exists to expand these supports for youth in legal guardianships and APPLA, as well as for families who have reunified with their children.

Community Referrals

One of the seven key strategies to the County's prevention plan, *Paving the Road to Safety for Our Children*, was to increase the capacity of the P&A networks; this expansion is now occurring. In addition to the work the P&A agencies do in primary prevention, they also target supports and services for DCFS-referred children and families who are receiving family reunification services, and those who have exited the public child-welfare system and need supports to prevent subsequent child maltreatment or DCFS involvement. These supports and services could help to increase and maintain permanency, and efforts to increase referrals to these agencies should be considered.

Target Youth Who Have Been in the System Three or More Years and Specialized Populations (Those with Mental Health Issues, LGBTQ Youth, Dual-Status Youth, etc.) to Increase Permanency

Youth, including non-minor dependents, who have been in the system three years or more are entitled to specialized permanency services.[33] These services may include medically necessary mental health services for youth, permanency-support core services to achieve, stabilize, and sustain the youth in a permanent family, as well as services designed to help the identified permanent family meet the youth's needs.[34] The County needs an expanded capacity to link families to currently available services.

An example of this kind of success is the ongoing pilot project to reduce the number of youth with multiple overstays at transitional shelter care locations. Through a partnership between DCFS' Accelerated Placement Team (APT) and the Department of Mental Health's Intensive Field-Capable Clinical Services Team, this pilot has helped stabilize placements for youth who have been in the system for multiple years and experienced multiple placement disruptions. In addition, campaigns should be targeted to Probation foster youth to help destigmatize this population and help potential families understand the trauma that these youth have experienced.

Strengthen Processes to Increase Stability

Placement

As mentioned previously, youth found the seven-day termination process disrespectful and discouraging and a barrier to creating connections with caregivers. Youth

[33] AB 1006 Foster Youth. (2017). Retrieved from https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB1006

[34] Ibid.

participating in the forums suggested that when a foster parent feels the need to terminate a placement, a meeting should be called with the caregiver, the children's social worker, and the youth to see if the dispute can be resolved. This suggestion by the youth is standard practice for DCFS' APT, which calls a CFT meeting upon receipt of a seven-day notice in an attempt to stabilize the placement. The APT model's approach is "whatever it takes," and many of its best practices should be reviewed to see what can be expanded Countywide.

Increase Visitation with Parents and Siblings

Most placements within the County are located an average of 20 to 30 miles from the home of the child's parent. To decrease the negative impacts of youth being placed far from their communities of origin, and to improve reunification options, DCFS should continue to explore all travel options, including private vendors, to help facilitate visitation for families, particularly while they are receiving reunification services.

Benefits Training

Trainings on the available benefits to foster youth, as well as their eligibility criteria, should be increased to broaden the knowledge base of youth, caregivers, social workers, and other stakeholders to help support the youth's permanency needs.

Culture Change

Permanency should be achieved not just by a lucky few, but should be the endgame for every foster youth. Although it often takes a back seat to immediate issues of safety and well-being, permanency must become a priority at a systemic level so that youth can successfully exit the system in a better position to become self-sufficient. Permanency should be discussed at every Child and Family Team meeting, and workers, lawyers, and judges should collaborate to discuss permanency at every six-month court review hearing. In addition, the timely completion of the CPA tool for all children as the WIC 366.21e hearing approaches will help establish viable permanency alternatives for children on a consistent basis.

Youth should be included in all decisions about their permanency plans and play an active role in determining the connections that will best help them become self-sufficient. Even if a youth does not express an interest in permanency, or says no the first time, conversations around permanency should be ongoing.

Casey Family Programs has provided a permanency-values training to some DCFS offices already, and that type of training could be expanded Countywide to help catalyze this culture change.

Increase Permanency for Older TAY

Benefits Knowledge

While becoming self-sufficient is usually the focus for TAY, permanency plays an important role in their achieving self-sufficiency and resiliency. Youth, caregivers, DCFS, and Probation need to be better informed of the existing incentives for obtaining permanency for these youth.

- Extended adoption and guardianship subsidies (42 U.S.C. 675 (8)(B)) for youth until age 21, if the youth entered into an adoption or guardianship at age 16 or older

- Independent-student status for the purposes of the Free Application for Federal Student Aid (FAFSA) for youth who were in foster care at age 13 or older, or in a guardianship arrangement before reaching the age of majority (20 U.S.C. 1087vv(d)(1))

- Medi-Cal to age 26 for youth with a suitable placement order on their 18th birthday; youth who were adopted or in legal guardianships may receive Medi-Cal until they are 21 years old

- Independent Living Program (ILP) benefits if a relative guardianship is established for a youth age 16 or older, or age 8 and older for guardianships with non-relatives

TAY have access to all of the permanency options that younger youth in foster care do. In fact, California AB 12 and AB 1712 require that DCFS and Probation increase the youth's voice and involvement in their own permanency, and continue to provide permanency planning options to the court for youth in extended foster care. TAY can access a number of different permanency options, including non-minor dependent adoptions, that leave them still eligible for AAP and ILP benefits.

TAY should be informed of these options, their benefits, and all self-sufficiency resources. Information should be readily available electronically, through DCFS's Youth Development Services (YDS) workers, and in other ways identified by youth.

Expand Capacity in Probation

Probation foster youth, who tend to be older, should also be targeted for permanency services where appropriate. While they are often reunified with their families, over 400 young people are currently probation foster youth. Probation's permanency unit serves only 47 of these, and receives cases only by referral. Probation should explore educating and cross-training deputy probation officers to expand their understanding of the importance of permanency for probation youth and to increase the number of referrals to this unit. Probation should also evaluate whether its permanency unit needs expanding to take on more cases.

Monitor Outcomes for Foster Youth Post-Permanency

To determine how effective County and community permanency programs are, research needs to be conducted on how youth fare after they exit the system with permanency. DCFS, Probation, the OCP, and the Center for Strategic Public-Private Partnerships should explore public-private partnership opportunities to conduct longitudinal studies on these youth and the various permanency services they receive to provide a clearer picture of the service gaps and needs for these youth and the effectiveness of permanency efforts.

Increase Communication Around the Various Permanency Efforts

As mentioned, not everyone is aware of all the permanency efforts occurring in the County. Communication efforts should be increased to eliminate duplicative efforts and to coordinate care. Cross-training to increase awareness about permanency's importance may also be helpful.

Leverage Existing Successful Permanency Models

In addition to some of the permanency practices being conducted in Los Angeles County, the County should explore leveraging other evidence-based models.

New York City: Social-Capital Building

New York City implemented a successful "social-capital building model" to achieve permanency for older youth who were unconnected to permanent families. The program model, based on the assumption that the best social capital for a vulnerable youth is a family through adoption or other permanent commitment, took three approaches: 1) child-specific recruitment through Permanency Action Recruitment Teams (PART), similar to our PCFTs, where a family-permanency advocate, a teen advocate, and the youth lead a meeting with relatives and other adults to help connect the youth with permanency resources; 2) 30 hours of parent education and training from a grantee agency, *You Gotta Believe*, to help prepare parents for a teen placement in their home (these trainings were available to anyone in the community and provided on a rotating basis); and 3) post-placement services that included an experienced adoptive parent being assigned to check in on the new family and provide them with guidance and parent support groups. An evaluation of this model found that by the end of the project period (four years), almost 50% of the youth (98 out of 198 referred teens) were placed in permanent homes.

Michigan: Family Reunification Program

In 1992, Michigan pilot-tested a family reunification program to reduce the number of children in out-of-home care and also reduce costs to the agency. The pilot provided four to eight months of services that included assessment, case management, transportation (24-hour service availability), flexible funds, in-home services, and two staff for each family. Families were required to participate in the assessment, family or individual therapy, and workshops on parenting. The evaluation showed that, 12 months after exiting the program, 73% of the 813 children in the treatment group returned home and remained safely with their families, compared with 69% of the comparison group. At 24 months after reunification, 81% of the treated families remained reunified versus 60% of the comparison group. Since the pilot, Michigan has expanded this program to 26 counties throughout the state, which account for 85% of all the foster children in Michigan.

Given the successful outcomes of these models, the County should explore possibly piloting these or other successful models.

NEXT STEPS

We recommend that the Board of Supervisors direct the OCP, in collaboration with DCFS, Probation, the Department of Mental Health, the Juvenile Court, and other key stakeholders, to develop a comprehensive plan to enhance permanency for system-involved youth, designed to, among other things, reduce the number of youth who age out of the system, and report back to the Board on its progress in 180 days.

COUNTY OF LOS ANGELES
OFFICE OF CHILD PROTECTION

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JUDGE MICHAEL NASH (RET.)
EXECUTIVE DIRECTOR

August 20, 2018

To: Supervisor Sheila Kuehl, Chair
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Janice Hahn
Supervisor Kathryn Barger

From: Judge Michael Nash (Ret.)
Executive Director, Office of Child Protection

PSYCHOTROPIC MEDICATION—YOUTH ENGAGEMENT AND TRANSITION-AGE YOUTH (TAY)

On August 22, 2017, the Board directed the Chief Executive Officer (CEO), in conjunction with the Executive Director of the Office of Child Protection (OCP), to coordinate with relevant County Departments and others "to coalesce existing efforts as the basis for a cohesive multi-year Countywide strategy that will support the self-sufficiency goals of TAY at the earliest stage possible . . . " The CEO has filed its response to the Board's motion. This memo is one of two adjunct memos to be filed by the OCP on important topics relevant to the Board's directive.

Each year, hundreds of youth in foster care under the care, custody, and control of both the Department of Children and Family Services (DCFS) and the Probation Department reach the age of 18. At that time, they either enter extended foster care or have their cases terminated.

Many of these youth are and have been taking psychotropic medications. When they reach age 18, they must be prepared to decide whether or not to continue and maintain their medication regimen.

In November 2017, Chapin Hall at the University of Chicago issued a brief titled, "The Use of Psychotropic Medications Over Time Among Foster Youth Transitioning to Adulthood" (Attachment 1). In that brief, the authors noted the need for oversight, stating:

> *Through the Child and Family Services Improvement Act of 2006, the U.S. Congress mandated state child welfare agencies to develop plans to monitor the use of psychotropic medications administered to children in state care.*

The authors further noted:

> *In California, the state with the largest foster youth population in the U.S., three Senate bills (SB 238, SB 484, and SB 1174) were enacted in 2015 and 2016 to improve oversight of psychotropic medication use among children in foster care . . . "*

At the end of the brief, the authors made the following important statement:

> *Professionals in the child welfare and mental health fields need to be prepared to engage foster youth in conversations that will increase youths' competency and comfort with making decisions about addressing their behavioral health issues.*

In 2012, the National Council of Juvenile and Family Court Judges (NCJFCJ) issued a resolution titled, "Resolution Regarding Judicial Oversight of Psychotropic Medications for Children Under Court Jurisdiction" (Attachment 2). In that resolution, the NDJFCJ stated:

> *WHEREAS, the NCJFCJ believes that judicial oversight means, at a minimum, that each court:*
>
> . . .
>
> - *Ensures children have been engaged at the earliest possible time in the medication process, allowing the court to have an understanding of their attitude toward medications and whether additional services or resources will be necessary to assure mediation compliance.*
>
> - *Ensures all children transitioning from child welfare or juvenile justice who are being administered psychotropic medications have been educated sufficiently to maintain their medication regimen and make decisions about their care, including possible adverse effects of sudden discontinuation of psychotropic medications.*

The resolution went on to resolve:

> *NCJFCJ shall promote the exercise of judicial leadership to convene and engage states and other jurisdictions, communities, and stakeholders in the child welfare and juvenile justice systems in meaningful partnerships to encourage and ensure, when necessary, the appropriate use of psychotropic medications for children and youth under court jurisdiction.*

To engage and prepare youth who turn 18 to be able to decide whether or not to continue their psychotropic medication regimen and to maintain their medication regimen if they so decide, requires an effort from all individuals and entities involved with them. These individuals and entities include caregivers, prescribing physicians, public health nurses, social workers, probation officers, Court-Appointed Special Advocate (CASA) volunteers, attorneys, and judicial officers.

This memo lists some systematic approaches to youth engagement that should help meet these goals. While overlap clearly exists between the two systems (child welfare and juvenile justice), the two are discussed separately. The following pages attempt to incorporate what has often been referred to as the involvement of the "whole village"[1] in our approach to the use of psychotropic medication on our system-involved youth.

Youth in the Child Welfare System

1. First on the list are the Judicial Council forms. The new forms were designed to engage the children and youth as well as other stakeholders.

JV-220–Application for Psychotropic Medication This form, completed by the social worker, includes information from the child and the caregiver, and provides an ongoing mechanism to receive input from the child.
JV-220(A)–Physician's Statement This form requires the physician to provide information to the child in an age-appropriate manner, and requires the physician to note the child's response.
JV-218–Child's Opinion About the Medicine This form was specifically devised to directly receive input from the child.
JV-219–Statement About Medication Prescribed **JV-222–Input on Application for Psychotropic Medication** These forms provide an opportunity for caregivers, parents, teachers, CASAs, attorneys, and others to provide information about the use of the medication.
JV-224–County Report on Psychotropic Medication This form, which is used for all progress reports and status-review hearings, specifically requests input from the child.

2. The second mechanism is DCFS' Health & Medication Guide (Attachment 3), which lays out milestones to be achieved in engaging and preparing youth to handle their medication needs, and the role of social workers vis-à-vis caregivers, health and mental health providers, public health nurses, and others in helping youth achieve those milestones.

[1] The "whole village" consists of the members of the Psychotropic Medication Workgroup, which includes DCFS, Probation, the Department of Public Health, the Department of Mental Health, the Public Defender, the Alternate Public Defender, Children's Law Center, Los Angeles Dependency Lawyers, Inc., County Counsel, California Youth Connection, the County's Commission for Children and Families, CASA Los Angeles, and the Juvenile Court.

It is recommended that DCFS adopt these guidelines, train social workers on them, and ultimately implement them.

DCFS endorses the concepts within this guide, which the department developed several years ago. Social workers currently access the guide through LA KIDS and the Department will use the guide in pertinent trainings.

3. The third mechanism is the Children's Law Center (CLC) memorandum of October 20, 2017, on "Policy Recommendations to Promote Medical Decision-Making Readiness—Revised" (Attachment 4). Consistent with the DCFS guidelines, this memo outlines the role of the child's attorney in working with others to achieve the various engagement and preparation milestones.

   We ask that CLC formally adopt and implement these recommendations.

4. The fourth mechanism is the use of a brochure created by the Children's Bureau of the Administration on Children, Youth and Families within the U.S. Department of Health and Human Services, *Making Healthy Choices: A Guide on Psychotropic Medications for Youth in Foster Care* (Attachment 5).

   Beginning at least by age 12, it is recommended that this brochure be annually distributed to youth receiving psychotropic medications as long as they are under the court's jurisdiction.

   With ongoing efforts to achieve permanency, it is hoped that the number of these youth will be small. Annual distribution of this informative document is recommended because young people often lose things.

   Currently, along with an approved Psychotropic Medication Application (PMA), the DCFS PMA unit mails various informational documents to caregivers to be provided to youth. DCFS has now agreed that the PMA unit will begin including the Children's Bureau brochure in the informational packets that accompany approved PMAs mailed to caregivers and youth.

5. The fifth potential mechanism flows from a suggestion made by the California Youth Connection (CYC), a regular and important member of our Psychotropic Medication Workgroup.

   It is recommended that CYC work with the Department of Children and Family Services, the Probation Department, the Department of Mental Health, and others to develop trainings for youth designed to provide information on psychotropic medication, their own involvement in the process, decision-making, self-advocacy, and more.

6. The sixth mechanism stems from a Transition-Age Youth Transition Worksheet created by Court-Appointed Special Advocates (CASA). A draft Psychotropic Medication Youth Engagement Worksheet appears as Attachment 6.

Beginning at age 14 and as long as a youth is under court jurisdiction (until the age of 18), it is recommended that this worksheet be completed by the social worker and attached to the report for every status-review hearing. At those hearings, the court should inquire of youth who are present whether or not they have seen the form and have any comments. In addition, attorneys for the youth and/or caregiver and CASAs who are present should be asked whether they have reviewed the forms and believe the information contained therein is accurate, and be further asked for any other comment.[2]

DCFS and DPH have developed a plan whereby social workers preparing to submit a JV-224 form will prompt PHNs co-located in DCFS offices to complete the work-sheet for timely return to the CSW to attach to the JV-224 prior to court submission.

7. The last mechanism involves public health nurses (PHNs).

It is recommend that the Department of Public Health designate PHNs who are available for the purposes of advice and consultation for all youth, especially those who have reached the age of majority and beyond, and are still under court jurisdiction.

Youth in the Juvenile Justice System

1. First, the utilization of the Judicial Council forms is the same as in child welfare.

2. Second, ***it is recommended that the Making Healthy Choices brochure (Attachment 5) be annually distributed to all youth receiving psychotropic medications while they are under court jurisdiction.***

3. Third, ***it is recommended that the Probation Department work with CYC and other stakeholders to develop trainings that could be delivered to youth in camps, juvenile halls, and other placement locations.***

4. Fourth, ***it is recommended that the Psychotropic Medication Youth Engagement Worksheet (Attachment 6) be completed by Probation and attached to the final camp progress report and to reports for all status-review hearings.***

   Probation is in discussions with DPH to develop a plan to implement this recommendation.

If you have any questions, please contact me at (213) 893-1152 or by email at mnash@ocp.lacounty.gov, or your staff may contact Carrie Miller at (213) 893-0862 or by email at cmiller@ocp.lacounty.gov.

MN:CDM:eih

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[2] DCFS, Probation, and the Court have agreed to work with the OCP to develop an implementation plan for the worksheet over the next few months.

c: Chief Executive Office
Executive Office, Board of Supervisors
Alternate Public Defender
Chief Information Office
Child Support Services
Children and Family Services
County Counsel
County Library
District Attorney
Fire
Health Services
Human Resources
Mental Health
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Probation
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The Use of Psychotropic Medications over Time among Foster Youth Transitioning to Adulthood

By Keunhye Park, Nathanael J. Okpych, Mark E. Courtney

Introduction

High rates of psychotropic medication use among children and adolescents in foster care have concerned researchers (Breland-Noble et al., 2004; Brenner, Southerland, Burns, Wagner, & Farmer, 2014; Leslie et al., 2010; Raghavan et al., 2005) and led the federal government to respond (Sheldon, Berwick, & Hyde, 2011; U.S. Government Accountability Office, 2017). Through the Child and Family Services Improvement Act of 2006, the US Congress mandated state child welfare agencies to develop plans to monitor the use of psychotropic medications administered to children in state care (Congressional Research Service, 2017).

In California, the state with the largest foster youth population in the US, three senate bills (SB 238, SB 484, and SB 1174) were enacted in 2015 and 2016 to improve oversight of psychotropic medication use among children in foster care. SB 238 mandates that the state develop curriculum to train professionals involved with the oversight of children in foster care (e.g., foster parents, relative caregivers, group home staff, social workers, juvenile court judges, attorneys, and foster care public health nurses) on the authorization, uses, risks, benefits, oversight, and monitoring of psychotropic medications and mental health treatments. This bill also changed the authorization process for providing psychotropic medications to foster youth to ensure that caregivers and youth had an opportunity to provide input on the use of the medications being prescribed. SB 484 pertains to children in group home facilities; it requires psychotropic medications to be recommended by a physician and ordered by a juvenile court judicial officer and increases the monitoring, reporting, and oversight of psychotropic medication use in these facilities. Finally, SB 1174 orders prescribing physicians to share data with the Medical Board of California about physicians' prescription patterns when treating foster care children covered by Medi-Cal, California's Medicaid program. These data are intended to ensure appropriate uses of psychoactive medications and to create treatment guidelines that will be disseminated each year to physicians who provide

services reimbursed by Medi-Cal.[1] The passage of these bills followed a state audit reporting that child welfare jurisdictions failed to perform appropriate oversight of medication prescriptions to children in foster care (California State Auditor, 2016).

Most research to date on psychotropic drug use in foster care has focused on school-age children (e.g., Zima, Bussing, Crecelius, Kaufman, & Belin, 1999a) and reports that children in foster care are more likely than their peers not in care to be prescribed psychoactive medication and to be treated with more types of medications (dosReis et al., 2011). Previous research has shown that while between 4 and 10 percent of Medicaid-enrolled children used psychotropic medications, 30 to 43 percent of children in foster care used such medications (dosReis, Zito, Safer, & Soeken, 2001; Ferguson, Glesener, & Raschick, 2006; Zito, Safer, Zuckerman, Gardner, & Soeken, 2005; Zito et al., 2008). Less is known about psychotropic medication use among older adolescents in foster care and changes over time in their medication use. Some studies suggest that adolescents in care have higher rates of psychotropic drug use than younger children in care (Brenner et al., 2014; Raghavan & McMillen, 2008; Zima et al., 1999a). One large study of over 700 transition-age foster youths in three Midwestern states reported that the prevalence rates of both behavioral health problems and medication use declined from ages 17 to 19 (Courtney, Terao, & Bost, 2004; Courtney et al., 2005). Furthermore, another analysis of the same study found that, among youths who had a behavioral health problem, the proportion of youths who received behavioral health services (psychotropic medication, psychological counseling, or alcohol/drug treatment) decreased from age 17 to age 19 (Brown, Courtney, & McMillen, 2015). For instance, 61 percent of 17-year-olds with depressive symptoms received behavioral health services, which dropped to 45 percent for 19-year-olds with depressive symptoms.

While these studies provide a sense of trends in psychotropic medication use over time, we know even less about foster youths' perceptions of their psychotropic medications. Stigma around psychotropic drug use (e.g., secrecy, shame, limiting social interaction) is a commonly reported experience among adolescents who take these medications (Kranke, Floersch, Townsend, & Munson, 2010). From a developmental perspective, older adolescents have increased autonomy and agency about their medication decisions, such as weighing the costs and benefits of taking medication. Thus, youths' experiences with and perceptions of their medication use can potentially influence whether they continue treatment and adhere to prescribers' treatment recommendations.

In this memo, we explore the use of and experiences with psychotropic medications over time for California foster youth transitioning to adulthood. We also examine how psychotropic drug use differs for youth who have different types of behavioral health problems. Throughout this memo, "behavioral health problems" will be used to denote both mental health problems and alcohol/drug use problems.

Study Methods

This memo draws on information collected from two interview waves of the California Youth Transitions to Adulthood Study (CalYOUTH). CalYOUTH is a longitudinal study following over 700 transition-age adolescents who had been in foster care in California for at least six months (Courtney, Charles, Okpych, Napolitano, & Halsted, 2014; Courtney et al., 2016). Most respondents were 17 years old during the baseline interview conducted in 2013 and 19 years old during the follow-up interview conducted in 2015. This memo includes information from the 611 youths who completed both interview waves. The baseline interview used a stratified random sampling method to select

[1] In addition to these three laws, a fourth bill (SB 1291), enacted in 2016, focused on Specialty Mental Health Services, with some attention paid to psychotropic medication. SB 1291 requires that an external organization conduct annual mental health plan reviews of the number and types of mental health services provided to children in foster care. It also mandates that quality assessments be reported to the State Department of Health Care Services and then to county boards to assist with the creation of mental health service plans and performance outcomes metrics.

participants for the study. Sample weights are used in the current analysis to account for the sampling design and response rates. The findings reported in this memo represent estimates of the statewide population of foster youth who met CalYOUTH criteria (see Courtney et al., 2014 and Courtney et al., 2016 for more information about survey weights). In the tables and figures throughout this memo, we report findings from both age 17 and age 19, using unweighted frequencies and survey weighted percentages.

At each interview wave, a brief structured diagnostic tool was used to identify the presence of several current mental health disorders and substance use disorders (see Courtney et al., 2014 and Courtney et al., 2016 for more information). In this memo, we consider seven behavioral health problems that were assessed during both interview waves: major depressive episode, manic or hypomanic episode, social phobia, posttraumatic stress disorder, psychotic thinking,[2] alcohol use problems (abuse or dependence), and substance use problems (abuse or dependence).

In terms of psychotropic medication use, respondents were asked if they had received medications for their emotions in the past year. Furthermore, to gauge youths' experiences with their medication, we asked youth to respond to the following four statements: "medicine improves my mood or helps me concentrate or behave better," "I get along better with people when on medication," "my medicine gives me bad side effects," and "good things about medication outweigh the bad." For each statement, respondents could select from one of five responses, ranging from "strongly disagree" to "strongly agree." In this memo, we collapsed the five options into three categories that represent disagreement with the statement, a neutral stance, and agreement with the statement.[3] None of the items in this memo had more than 10 percent missing data.

The findings presented in this memo are organized in three sections. In the first section, we look at overall rates of behavioral health problems, medication use, and receipt of counseling. Differences in rates by gender, race/ethnicity, and sexual minority status[4] are also explored. In the second section, we examine rates of specific behavioral health problems, as well as the rates of medication use among youths who had those specific behavioral health problems. Finally, the third section considers youths' experiences with and perceptions of the effects of their medication.

Findings

A snapshot of behavioral health problems, medication use, and receipt of counseling over time

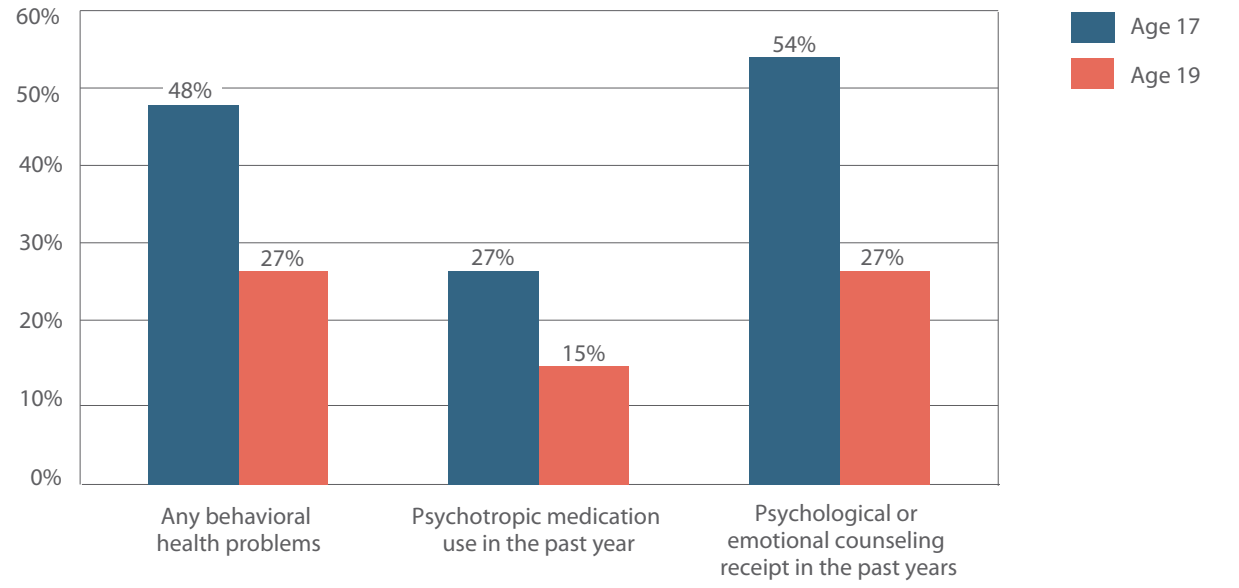
The three sets of bars in Figure 1 display (1) the proportion of respondents with at least one of the seven current behavioral health problems that were screened at each interview wave, (2) the proportion of respondents who reported taking psychotropic medications at each interview wave, and (3) the proportion of respondents who reported receiving psychological or emotional counseling at each interview wave. All three prevalence rates declined from age 17 to age 19. The proportion of youth with a behavioral health problem dropped by more than two-fifths ($p < .001$), as did the proportion of youth taking psychotropic medication ($p < .001$). The proportion of youth receiving counseling dropped by half from age 17 to age 19 ($p < .001$).

[2] Symptoms of psychotic thinking were assessed using different instrument tools at each interview wave. The MINI-KID was used at age 17 (Sheehan et al., 1998, 2010), and the Psychoticism Dimension of the Symptoms Checklist-90-Revised (SCL-90-R) was used at age 19 (Derogatis, 1996; Derogatis & Unger, 2010).

[3] The original response options for these questions ranged from 1 through 5 (1 = strongly agree; 2 = agree; 3 = neither agree nor disagree; 4 = disagree; 5 = strongly disagree). The three-category measure used in this analysis included an affirmative response ("agreed" or "strongly agreed"), a neutral response ("neither agree nor disagree"), and a disagreeing response ("disagreed" or "strongly disagreed").

[4] Sexual minority status was assessed by one item asking about youths' sexual orientation. The response options included: 100% heterosexual, mostly heterosexual, bisexual, mostly homosexual, 100% homosexual, and not sexually attracted to either males or females. A binary variable with two categories was created based on whether youth reported being 100% heterosexual or not.

Figure 1.
Proportion of Youths with Behavioral Health Problems, Proportion of Youths Using Medication for Emotions, and Proportion of Youths Receiving Counseling Services (n = 611)



We found statistically significant differences in rates of behavioral health problems by gender and sexual orientation. Females were more likely than males to screen positive for a behavioral health problem at age 17 (53% vs. 41%, $p < .05$). Additionally, a greater proportion of sexual minority youths than youths who identified as 100 percent heterosexual screened positive for at least one behavioral health disorder at both age 17 (66% vs. 44%, $p < .001$) and at age 19 (40% vs. 23%, $p < .01$). There were no statistically significant differences by race and ethnicity in the prevalence rates of behavioral health problems.

Regarding psychotropic medication use, there were no significant racial/ethnic differences or gender differences at age 17 or at age 19. However, differences were found by sexual orientation. Sexual minority youths were more likely than youths who identified as 100 percent heterosexual to receive psychotropic medications at age 17 (37% vs. 23%, $p < .01$) and at age 19 (22% vs. 13%, $p < .05$).

Lastly, the proportion of youths receiving psychological or emotional counseling significantly differed by gender and sexual orientation, but did not differ by race and ethnicity. Females were more likely than males to receive mental health counseling at age 17 (59% vs. 45%, $p < .01$). Moreover, a greater proportion of sexual minority youths than youths who identified as 100 percent heterosexual reported receiving counseling services at age 17 (67% vs. 48%, $p < .001$) and at age 19 (35% vs. 24%, $p < .05$). We also examined the proportions of youths receiving counseling services among those who used psychotropic medications. The results showed that the vast majority of youths using psychotropic medications also received counseling services at both ages (84% at age 17, 80% at age 19).

A closer look at prevalence rates of specific behavioral health problems and prevalence rates of psychotropic medication use among those with behavioral health problems

In the previous section, we looked at overall prevalence rates of behavioral health problems and the use of psychotropic medications at age 17 and age 19. In this section, we take a closer look at specific mental health and substance use problems and how the prevalence rates changed from age 17 to age 19. We also examine the proportions of youths who used psychotropic

medications among those with a specific behavioral health problem and how these prevalence rates differed between age 17 and age 19.

The left columns of Table 1 ("% screened positive for disorder") present the prevalence rates of specific behavioral health problems at age 17 and age 19 among all participants in each interview wave. The middle columns of Table 1 ("% receiving psychotropic medications, among those who screened positive for disorder") present the proportion of respondents who used psychotropic medications, among the youths who had screened positive for the corresponding behavioral health problem. For example, at age 17, 48 percent of respondents screened positive for one or more behavioral health problems. Among youths with at least one behavioral health problem at age 17, almost 38 percent had used psychotropic medications in the past year.

At age 17, 48 percent of youths screened positive for either a mental health or substance use disorder and 12 percent had a co-occurring mental health problem and a substance use problem. The most prevalent behavioral health disorders were a drug use disorder (nonalcohol) and depression. At age 19, 27 percent of youths screened positive for either a mental health or substance use disorder, and 6 percent had both mental health and substance use problems. The most prevalent behavioral health disorders were also depression and nonalcohol drug use problems, as well as symptoms of psychotic thinking. Prevalence rates of behavioral health problems were generally lower at age 19 than at age 17, with significant declines found for most disorders except for psychoticism and social phobia.

As shown in the middle columns of Table 1, rates of psychotropic medication use among youths with behavioral health problems were generally lower at age 19 than at age 17. The prevalence rate of medication use declined by 12 percentage points for youths with any behavioral health problems ($p < .05$). The prevalence rate of psychotropic medication use dropped by 26 percentage points for youths with co-occurring mental health and substance use disorders ($p < .01$). Looking at specific behavioral health problems, significant decreases were found in medication use from age 17 to age 19 in youths with the following disorders: a manic episode (a decrease of 26 percentage points; $p < .05$), an alcohol use disorder (a decrease of 25 percentage points; $p < .01$), and a nonalcohol drug use disorder (a decrease of 18 percentage points; $p < .05$). However, additional analyses found that the drop in psychotropic medication use among youths with an alcohol/drug use problem was explained, in part, by the accompanying drop in the prevalence of co-occurring mental health problems from age 17 to age 19.[5]

Lastly, although not the focus of this memo, we also examined the proportion of youth with behavioral health problems that had received counseling.[6] The right columns of Table 1 ("% receiving counseling, among those who screened positive for disorder") present the proportion of respondents who received emotional or psychological counseling, among the youths who had screened positive for the corresponding behavioral health problem. Overall, greater proportions of youth with behavioral health problems received counseling than psychotropic medications. For example, at age 17, about 65 percent of youths with a behavioral health problem received counseling while 38

[5] Note that the proportion of youths with co-occurring disorders dropped from 11.5% to 5.9% from age 17 to age 19. That is, among youths with a substance use problem at each interview wave, a smaller percentage at age 19 than at age 17 also had a mental health problem. We suspected that this drop in co-occurring mental health problems may have accounted for some of the decline in psychotropic medication use observed among youths with substance use disorders. To investigate this, we compared the rates of psychotropic medication use across ages among youths who only had a substance use problem (i.e., no co-occurring mental health problem). In this analysis, the difference in rates of psychotropic medication use between ages was just 10 percentage points for an alcohol use disorder (30% vs. 20%), 13 percentage points for a drug use disorder (35% vs. 22%), and 14 percentage points for any alcohol/drug disorders (33% vs. 19%). None of these three differences were statistically significant ($p > .10$). This suggests that the decline in the psychotropic medication use among youths with substance use disorders is explained, at least in part, by the drop in the prevalence of co-occurring mental health problems

[6] At each interview wave, the study participants were asked the following question about their receipt of outpatient mental health services: "In the past year, have you received psychological or emotional counseling?"

Table 1.
Prevalence of Specific Behavioral Health Problems (n = 611) and Psychotropic Medication Use among Youths with Behavioral Health Problems (n = 177 at age 17, n = 106 at age 19)

	% screened positive for disorder		Between ages	% receiving psychotropic medications, among those who screened positive for disorder		Between ages	% receiving counseling, among those who screened positive for disorder		Between ages
	Age 17	Age 19	*p*	Age 17	Age 19	*p*	Age 17	Age 19	*p*
Mental health and/or substance use disorders									
Either mental health disorder or substance use disorder	48.0	27.3	***	37.8	25.7	*	64.8	41.5	***
Both mental health disorder and substance use disorder	11.5	5.9	**	54.2	28.1	**	72.6	51.1	*
Mental health disorders									
Major depression episode	21.5	9.6	***	45.7	40.1		74.9	60.6	
Mania (manic episode or hypomanic episode)	13.5	2.3	***	45.5	19.5	*	70.5	39.5	*
Psychotic thinking	7.9	9.0		38.9	35.1		58.9	51.9	
PTSD	7.2	3.0	**	62.6	39.3		73.6	46.6	
Social phobia	5.0	4.8		46.3	38.9		63.8	67.2	
Any mental health disorder	33.1	18.7	***	40.1	28.6	*	69.5	50.0	**
Substance use disorders									
Alcohol abuse or dependence	12.7	8.5	*	44.4	19.8	**	58.9	32.3	**
Drug abuse or dependence	22.7	9.4	***	44.8	26.5	*	65.6	38.7	***
Any substance use disorder	26.5	14.1	***	42.2	23.0	**	62.3	35.0	***

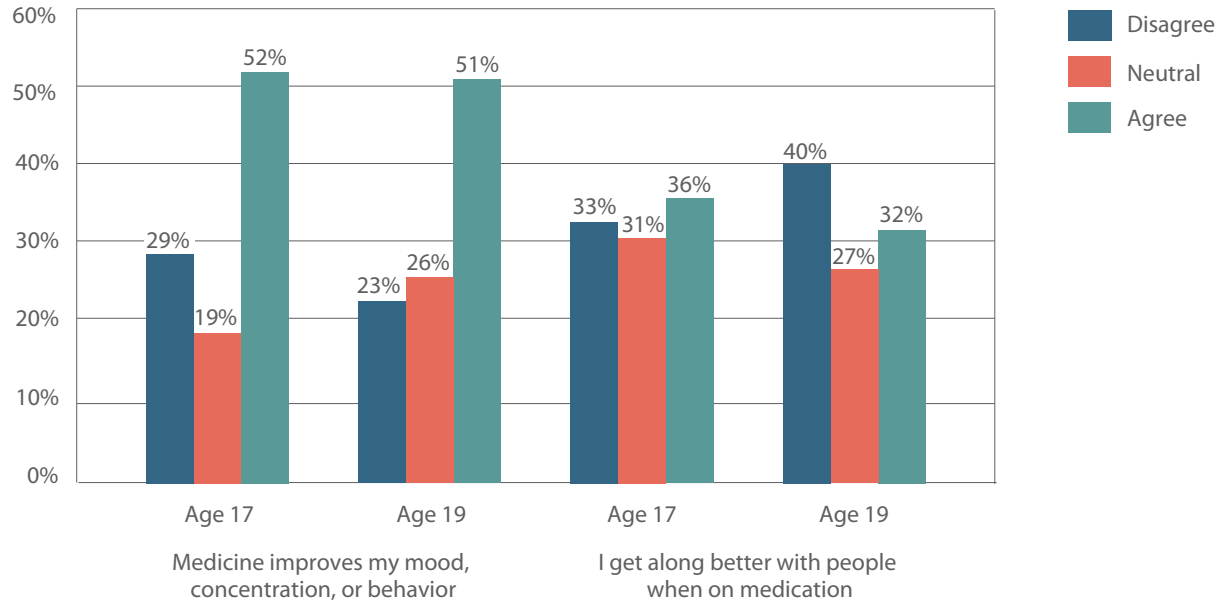
*p < .05; **p < .01; ***p < .001

percent of youths received psychotropic medications. As shown in the table, youth with behavioral health problems experienced a drop in counseling use from age 17 to age 19. The proportion of youths who had received counseling declined by 23 percentage points for youths with any behavioral health problem (p < .001) and by 22 percentage points for youths with co-occurring mental health and substance use disorders (p < .05). Looking at specific behavioral health problems, significant decreases were found in counseling use from age 17 to age 19 for the following disorders: a manic episode (a decrease of 31 percentage points; p < .05), an alcohol use disorder (a decrease of 27 percentage points; p < .01), and a nonalcohol drug use disorder (a decrease of 27 percentage points; p < .001).

Youths' experiences with and perceptions of psychotropic medication use

This section provides information about youths' perceptions of the effects, benefits, and downsides of their psychotropic medication, at both age 17 and age 19. Importantly, for all comparisons between ages 17 and 19 described below, no statistically significant differences were found. However, this analysis in particular includes relatively small numbers of youths at each interview wave who reported using psychotropic medication. Thus, there may have been inadequate statistical power to detect differences in medication experiences.

Figure 2.
Youths' Perceptions of the Effect of Psychotropic Medication on Their Mood and Interaction with Others (*n* = 177 at age 17, *n* = 106 at age 19)



As seen in the left half of Figure 2, respondents using psychotropic medication were asked whether their medication improved their mood, concentration, or behavior. At both ages 17 and 19, about one-half of youths agreed that their medication had those positive benefits, while the rest had a neutral or negative view about the benefits.

The right half of Figure 2 shows that at age 17, roughly equivalent proportions (about one-third) of youths disagreed, had a neutral view, or agreed that medications helped them get along better with others. At age 19, somewhat similar proportions of youth had positive, negative, and neutral perceptions of the effects of psychotropic medications, with no statistically significant difference between responses at 19 and those two years earlier.

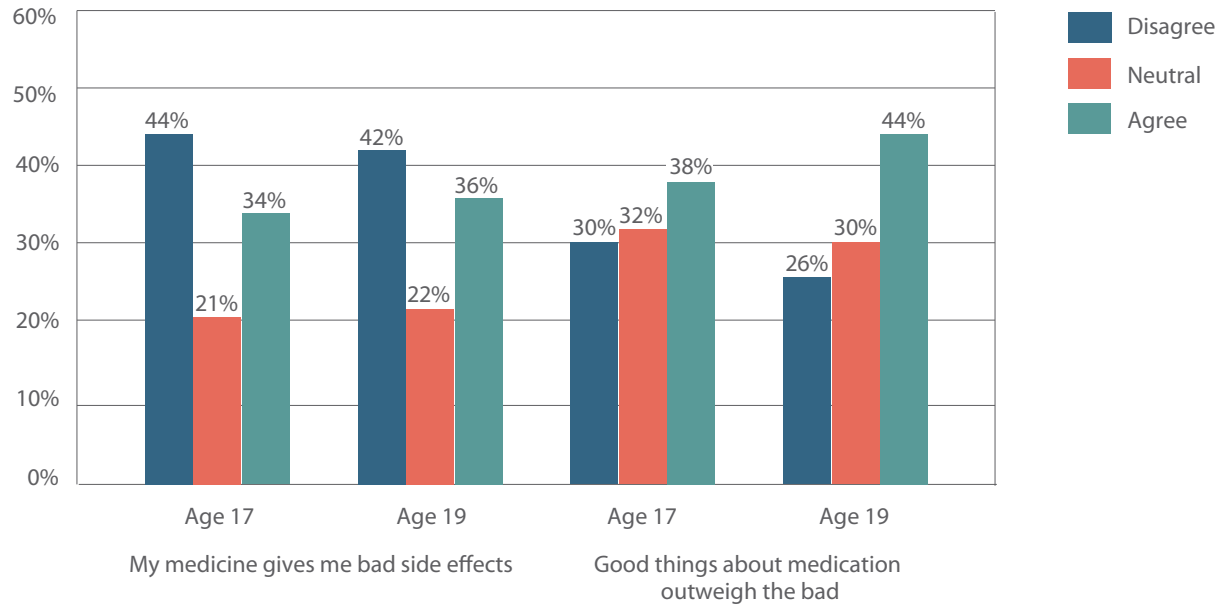
Respondents were also asked about the negative side effects of their psychotropic medications, and their responses appear in the left half of Figure 3. Responses about negative side effects were very similar between ages 17 and 19. At both ages, over four in ten youths disagreed that their medication gave them bad side effects, over two in ten were neutral about the negative side effects, and less than four in ten reported that there were negative side effects from their medication.

A final question pertained to the net benefits of psychotropic medications, asking respondents whether the good things about their medication outweighed the bad things. The right half of Figure 3 shows that the majority of youths who had used medication reported a positive or neutral view with respect to whether the advantages of using medications outweighed the disadvantages (70% at age 17, 74% at age 19).

Study Limitations

It is important to note several limitations of the study. First, the measures of behavioral health disorders collected in this study were self-reported by respondents using a brief screening tool rather than a formal diagnostic assessment. Second, time constraints of conducting the survey prevented us from gathering more specific information on youths'

Figure 3.
Youths' Perceptions of the Side Effects and Net Benefits of Their Psychotropic Medication (*n* = 177 at age 17, *n* = 106 at age 19)



psychotropic medication. For example, we did not have data on the specific types of medication youths were taking, how many medications youths were prescribed, and which mental health problem(s) the medication was intended to treat. Moreover, the question about psychotropic medications asked about "medications for emotions," which may not have captured the total array of psychoactive drugs used to treat behavioral health problems. Information was also not collected on the types of side effects youths experienced or on the effects that they felt were most problematic or concerning. This information would be especially relevant when examining benefits and side effects of specific types of psychotropic medications, which may have different sets of side effects. Small sample sizes, particularly in the analyses involving subgroups of the study sample (i.e., youths with a specific behavioral health problem, youths who used psychotropic medications), may have limited the statistical power to detect significant differences. Finally, the study findings may not represent the experiences of youth in other states, due to differences in youth characteristics as well as differences in policies and practices in the child welfare systems and behavioral health care systems.

Summary and Implications

Overall rates of psychotropic medication use at age 17

Among CalYOUTH participants, 27 percent of 17-year-olds indicated that they had used medication for their emotions in the past year. These estimates are consistent with recent estimates based on administrative records of the statewide prevalence of psychotropic medication use, which reported that 26 percent of children ages 16 and 17 in California foster care were prescribed psychotropic medication during a 12-month period (April 2016 through May 2017; California Child Welfare Indicators Project [CCWIP], 2017). There were differences between the CalYOUTH Study and state administrative records in the source of data, the ages of the samples, and the measurement of psychotropic

medication use.[7] Despite these differences, the psychoactive drug use estimates were similar between studies.

Consistent with prior studies, the high rates of psychotropic medication use among older adolescents in foster care call for attention from child welfare professionals, social workers, clinicians, and caregivers. One promising finding is that counseling services for emotional and psychological problems were used by more youth than were psychotropic medications. This suggests that psychotropic medications are not being used as the predominant treatment of behavioral health problems. Moreover, the fact that the vast majority of youth using psychotropic medications were also seeing a counselor at the time suggests that their use of these drugs is likely done with the oversight of a mental health professional.

Differences in psychotropic medication use by subgroups

When looking at prevalence rates by subgroups (gender, race/ethnicity, and sexual orientation), sexual minority youths were more likely than their sexual majority counterparts to have behavioral health problems, to use psychotropic medications, and to receive psychological or emotional counseling. Additional analyses (not shown) indicate that, among youths with a behavioral health problem, sexual minority youths were more likely than sexual majority youths to have received psychotropic medications (47% vs. 33% at age 17, $p < .05$; 38% vs. 19% at 19, $p < .05$). As sexual minority youth are often likely to experience marginalization and exclusion in their families, communities, and schools (Hammack & Cohler, 2011), it is essential to ensure that their psychotropic medication yields clinical benefits to them and is accompanied by treatment that addresses social stigma, isolation, and discrimination. In this study, nearly one-fourth of respondents at age 17 reported their sexual orientation as being something other than 100 percent heterosexual. Future work should further explore differences in the use of psychotropic medications by sexual orientation, including differences in behavioral health problems that prompt the use of psychotropic medication.

Changes in psychotropic medication use from age 17 to age 19

Our findings show notable changes in overall rates of behavioral health problems and medication use from age 17 to age 19. Among all respondents, both prevalence rates of behavioral health problems and psychotropic medication use dropped from age 17 to age 19. Among youths with a behavioral health problem, the rate of medication use also declined significantly from age 17 to age 19. The findings are consistent with existing studies that have examined trends in service usage, showing that foster youth with behavioral health issues transitioning to adulthood are less likely to receive ongoing treatment as they reach adulthood (Brown et al., 2015; Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001). The significant decline in medication use was observed among youths who screened positive for any mental health problem at ages 17 and 19. While the significant drops in medication use were also found in youths with any alcohol/drug use problems at ages 17 and 19, this was explained, at least in part, by the accompanying decrease in youths with co-occurring mental health problems.

Why might we see declines over time in psychotropic medication use?

Decreases in medication use between ages 17 and 19 among youths with behavioral health problems could be explained by a confluence of structural barriers, changes in living context, and changes in personal preferences. Structural barriers may include discontinuity in

[7] There are some differences between the CalYOUTH Study and the California Department of Social Services (CDSS) in how psychotropic medication use was measured. First, the CalYOUTH Study analyzed self-reports of medication use , while the CDSS measure came from administrative data on paid claims from Medi-Cal pharmacy providers. Second, the CalYOUTH Study sample (mostly 17-year-olds) was older than the adolescents in the CDSS data (16- and 17-year-olds). Third, the CalYOUTH Study asked youth a general question about "medications [they] received for [their] emotions," whereas the CDSS measure captured classes of medications designed to treat specific psychological disorders (i.e., anxiolytic agents, antidepressants, mood stabilizers, antipsychotic medications, anti-Parkinson agents, hypnotics, medications for dementia, and psychostimulants; CCWIP, 2017).

systemic supports upon exit from care, challenges in accessing services or navigating services, or difficulties with transportation and appointment availability (Brown et al., 2015; Dworsky, Ahrens, & Courtney, 2013; Reilly, 2003; Sakai et al., 2014).

Changes in living context might also explain the drop in medication use as youth transition to adulthood. At age 17, more than half of the participants lived in a placement with a therapeutic component (31% were placed in therapeutic foster care homes and 23% resided in a group home or residential treatment center). At age 19, fewer youths resided in placements with more restrictions or a therapeutic component (e.g., 7% lived in therapeutic foster homes and 15% lived in transitional housing placements). The majority of youths at age 19 lived in relative or nonrelative foster homes (27%), in supervised independent living placements (24%), were out-of-care and lived with friends or relatives or in their own place (18%), or lived in some other setting (9%). Compared to the living arrangements at age 17, on average, the places youths lived at age 19 had less supervision and support by professionals or adults who are in a position to encourage youths to take advantage of needed behavioral health services and help them navigate the steps needed to receive medication (e.g., completing paperwork, scheduling an appointment, finding transportation, refilling prescriptions).

Furthermore, changes in personal preferences about medication use might also factor in to these trends. As youth become more independent in making choices during the transition to adulthood, their perceptions about side effects of medication, their desire to deal with behavioral health problems on their own, and their willingness to seek nondrug treatments may influence their decision to use psychotropic medications. More research is needed to explain the downward trend in medication use as foster youth transition to adulthood.

Youths' experiences with psychotropic medications

In terms of medication experiences, overall our findings suggest that most youths had favorable or neutral views about the effects of their psychotropic medications. Those views did not change significantly over time. However, a nontrivial minority of participants at each interview wave expressed negative views or experiences—they felt that their medication did not improve their mood or their interactions with others, they experienced negative side effects, or they did not perceive that the positive aspects of their medication outweighed the negative aspects. From a quality assurance perspective, it is important to consider youths' negative reports about their medication experiences because this could signal an issue with their current prescriptions (e.g., dosage or type(s) of medication) or a need for a different or an additional treatment approach. Further, included in this population are youths approaching adulthood or who have reached the age of majority. From a consumer's perspective, since these young people exercise a greater degree of autonomy and discretion in their use of psychotropic medications than younger children do, information collected about their experiences accessing and navigating services, their interactions with prescribers, and their views about medication benefits are important indicators of treatment satisfaction and service performance. These data may be particularly important for young people living in placements where there is less oversight and support and where the responsibility falls on them for obtaining and using psychotropic medications.

These findings also have implications for professionals working with transition-age foster youth who take psychotropic medications. The ways in which youths come to see and understand their need for medication, the benefits of medication, and interpretation of the side effects are co-constructed through dialogues youths have with providers, professionals, and other significant individuals in their lives (Longhofer, Floersch, & Okpych, 2011; Townsend, Floersch, & Findling, 2009). Thus, these people play an important role in shaping how youth view themselves in relation to their behavioral health issues, how youth make sense of ambivalence and other feelings around taking medication, and whether youth stick to the treatment regimens to increase the chances that the medication will have its intended benefits. Professionals in the child

welfare and mental health fields need to be prepared to engage foster youth in conversations that will increase youths' competency and comfort with making decisions about addressing their behavioral health issues.

References

Breland-Noble, A. M., Elbogen, E. B., Farmer, E. M., Dubs, M. S., Wagner, H. R., & Burns, B. J. (2004). Use of psychotropic medications by youths in therapeutic foster care and group homes. *Psychiatric Services, 55*(6), 706–708.

Brenner, S. L., Southerland, D. G., Burns, B. J., Wagner, H. R., & Farmer, E. M. (2014). Use of psychotropic medications among youth in treatment foster care. *Journal of Child and Family Studies, 23*(4), 666–674.

Brown, A., Courtney, M. E., & McMillen, J. C. (2015). Behavioral health needs and service use among those who've aged-out of foster care. *Children and Youth Services Review, 58*, 163–169.

California Child Welfare Indicators Project. (2017). *Outcome Measure 5a.1–Use of psychotropic medication among youth in foster care.* Retrieved from: http://cssr.berkeley.edu/ucb_childwelfare/CDSS_5A.aspx

California State Auditor. (2016). *California's foster care system: The state and counties have failed to adequately oversee the prescription of psychotropic medications to children in foster care.* Retrieved from: http://www.auditor.ca.gov/pdfs/reports/2015-131.pdf

Congressional Research Service. (2017). *Child welfare: Oversight of psychotropic medication for children in foster care.* Retrieved from: https://www.everycrsreport.com/files/20170217_R43466_74f90fe0b0a68eead9696c2dd87a56129a95e227.pdf

Courtney, M. E., Charles, P., Okpych, N. J., Napolitano, L., Halsted, K. (2014). *Findings from the California Youth Transitions to Adulthood Study (CalYOUTH): Conditions of foster youth at age 17.* Chicago, IL: Chapin Hall at the University of Chicago. Retrieved from: http://fosteringsuccessmichigan.com/uploads/misc/CalYOUTH_Conditions_of_Foster_Youth_at_Age_17_report.pdf

Courtney, M. E., Dworsky, A. L., Ruth, G., Keller, T., Havlicek, J., & Bost, N. (2005). *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at age 19*. Chicago, IL: Chapin Hall Center for Children at the University of Chicago. Retrieved from: http://www.chapinhall.org/sites/default/files/ChapinHallDocument_4.pdf

Courtney, M. E., Dworsky, A., Cusick, G., Keller, T., Havlicek, J., & Perez, A. (2007). *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at age 21*. Chicago, IL: Chapin Hall Center for Children at the University of Chicago. Retrieved from: http://www.chapinhall.org/sites/default/files/ChapinHallDocument_2.pdf

Courtney, M. E., Dworsky, A., Lee, J. A., & Raap, M. (2010). *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at ages 23 and 24.* Chicago, IL: Chapin Hall at the University of Chicago. Retrieved from: http://www.chapinhall.org/sites/default/files/Midwest_Study_Age_23_24.pdf

Courtney, M. E., Dworsky, A., Brown, A., Cary, C, Love, K., & Vorhies, V. (2011). *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at age 26.* Chicago, IL: Chapin Hall at the University of Chicago. Retrieved from: http://www.chapinhall.org/sites/default/files/Midwest%20Evaluation_Report_4_10_12.pdf

Courtney, M. E., Okpych, N. J., Charles, P., Mikell, D., Stevenson, B., Park, K., Kindle, B., Harty, J., & Feng, H. (2016). *Findings from the California Youth Transitions to Adulthood Study (CalYOUTH): Conditions of youth at age 19.* Chicago, IL: Chapin Hall at the University of Chicago. Retrieved from: http://www.chapinhall.org/sites/default/files/CY_YT_RE0516_4.pdf

Courtney, M. E., Piliavin, I., Grogan-Kaylor, A., & Nesmith, A. (2001). Foster youth transitions to adulthood: A longitudinal view of youth leaving care. *Child Welfare, 80*(6), 685–717.

Courtney, M. E., Terao, S., & Bost, N. (2004). *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Conditions of youth preparing to leave state care.* Chicago, IL: Chapin Hall Center for Children at the University of Chicago. Retrieved from: https://www.chapinhall.org/sites/default/files/CS_97.pdf

Derogatis, L. R. (1996). *SCL-90-R: Symptom Checklist-90-R: Administration, scoring, and procedures manual.* New York, NY: Pearson.

Derogatis, L. R. & Unger, R. (2010). Symptom Checklist-90-Revised. *Corsini Encyclopedia of Psychology, 4th edition* (pp. 1–2). Hoboken, NJ: John Wiley and Sons.

dosReis, S., Yoon, Y., Rubin, D.M., Riddle, M.A., Noll, E., & Rothbard, A. (2011). Antipsychotic treatment among youth in foster care. *Pediatrics, 128*(6), e1459–e1466.

dosReis, S., Zito, J. M., Safer, D. J., & Soeken, K. L. (2001). Mental health services for youths in foster care and disabled youths. *American Journal of Public Health, 91*(7), 1094–1099.

Dworsky, A., Ahrens, K., & Courtney, M. (2013). Health insurance coverage and use of family planning services among current and former foster youth: Implications of the health care reform law. *Journal of Health Politics, Policy and Law, 38*(2), 421–439.

Ferguson, D. G., Glesener, D. C., & Raschick, M. (2006). Psychotropic drug use with European American and American Indian children in foster care. *Journal of Child & Adolescent Psychopharmacology, 16*(4), 474–481.

Hammack, P. L., & Cohler, B. J. (2011). Narrative, identity, and the politics of exclusion: Social change and the gay and lesbian life course. *Sexuality Research and Social Policy, 8*(3), 162–182.

Kranke, D., Floersch, J., Townsend, L., & Munson, M. (2010). Stigma experience among adolescents taking psychiatric medication. *Children and Youth Services Review, 32*(4), 496–505.

Leslie, L. K., Mackie, T., Dawson, E. H., Bellonci, C., Schoonover, D. R., Rodday, A. M., . . . Hyde, J. (2010). Multi-state study on psychotropic medication oversight in foster care. Boston, MA: Tufts Clinical and Translational Science Institute.

Longhofer, J., Floersch, J., & Okpych, N. (2011). Foster youth and psychotropic treatment: Where next? *Children and Youth Services Review, 33*(2), 395–404.

McMillen, J. C., & Raghavan, R. (2009). Pediatric to adult mental health service use of young people leaving the foster care system. *Journal of Adolescent Health, 44*(1), 7–13.

Raghavan, R., & McMillen, J. C. (2008). Use of multiple psychotropic medications among adolescents aging out of foster care. *Psychiatric Services, 59*(9), 1052–1055.

Raghavan, R., Zima, B. T., Andersen, R. M., Leibowitz, A. A., Schuster, M. A., & Landsverk, J. (2005). Psychotropic medication use in a national probability sample of children in the child welfare system. *Journal of Child & Adolescent Psychopharmacology, 15*(1), 97–106.

Reilly, T. (2003). Transition from care: Status and outcomes of youth who age out of foster care. *Child Welfare, 82*(6), 728–746.

Sakai, C., Mackie, T. I., Shetgiri, R., Franzen, S., Partap, A., Flores, G., & Leslie, L. K. (2014). Mental health beliefs and barriers to accessing mental health services in youth aging out of foster care. *Academic Pediatrics, 14*(6), 565–573.

Sheehan, D. V., Lecrubier, Y., Sheehan, K. H., Amorim, P., Janavs, J., Weiller, E., . . . Dunbar, G. C. (1998). The Mini-International Neuropsychiatric Interview (MINI): The development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of Clinical Psychiatry, 59*, 22–33.

Sheehan, D. V., Sheehan, K. H., Shytle, R. D., Janavs, J., Bannon, Y., Rogers, J. E., . . . Wilkinson, B. (2010). Reliability and validity of the Mini International Neuropsychiatric Interview for Children and Adolescents (MINI-KID). *The Journal of Clinical Psychiatry, 71*(3), 313–326.

Sheldon, G., Berwick, D., & Hyde, P. (2011). *Joint letter to state child welfare, Medicaid, and mental health authorities on the use of psychotropic medication for children in foster care & substance abuse and mental health services administration.* Retrieved from: https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-11-23-11.pdf

Townsend, L., Floersch, J., & Findling, R. L. (2009). The conceptual adequacy of the Drug Attitude Inventory for measuring youth attitudes toward psychotropic medications: A mixed methods evaluation. *Journal of Mixed Methods Research, 4*(1), 32–55.

U.S. Government Accountability Office. (2017). *Foster care: HHS has taken steps to support states' oversight of psychotropic medications, but additional assistance could further collaboration.* (GAO Publication No. GAO-17-129). Retrieved from: https://www.gao.gov/assets/690/681916.pdf

Zima, B. T., Bussing, R., Crecelius, G. M., Kaufman, A., & Belin, T. R. (1999a). Psychotropic medication treatment patterns among school-aged children in foster care. *Journal of Child and Adolescent Psychopharmacology, 9*(3), 135–147.

Zima, B. T., Bussing, R., Crecelius, G. M., Kaufman, A., & Belin, T. R. (1999b). Psychotropic medication use among children in foster care: Relationship to severe psychiatric disorders. *American Journal of Public Health, 89*(11), 1732–1735.

Zito, J. M., Safer, D. J., Gardner, J. F., Boles, M., & Lynch, F. (2000). Trends in the prescribing of psychotropic medications to preschoolers. *JAMA, 283*(8), 1025–1030.

Zito, J. M., Safer, D. J., Sai, D., Gardner, J. F., Thomas, D., Coombes, P., Dubowski, M., & Mendez-Lewis, M. (2008). Psychotropic medication patterns among youth in foster care. *Pediatrics, 121*(1), e157–e163.

Zito, J. M., Safer, D. J., Zuckerman, I. H., Gardner, J. F., & Soeken, K. (2005). Effect of Medicaid eligibility category on racial disparities in the use of psychotropic medications among youths. *Psychiatric Services, 56*(2), 157–163.

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Related Publications

Okpych, N. J., Courtney, M., & Dennis, K. (2017). *Memo from CalYOUTH: Predictors of high school completion and college entry at ages 19/20.* Chicago, IL: Chapin Hall at the University of Chicago.

Courtney, M. E., Park, E., & Okpych, N. J. (2017). *Memo from CalYOUTH: Factors associated with remaining in foster care as young adults.* Chicago, IL: Chapin Hall at the University of Chicago.

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RESOLUTION REGARDING JUDICIAL OVERSIGHT OF PSYCHOTROPIC MEDICATIONS FOR CHILDREN UNDER COURT JURISDICTION

WHEREAS, Judges recognize that each child under court jurisdiction is unique, valued and entitled to individualized attention;

WHEREAS, Medicaid data indicate children in foster care are prescribed psychotropic medications far more often than children in the general population;

WHEREAS, Judges in child welfare and juvenile justice cases are responsible for overseeing the safety and well-being of children under court jurisdiction;

WHEREAS, the NCJFCJ believes that this oversight responsibility extends to children prescribed psychotropic medications, including ensuring that medications are safe and appropriate; and

WHEREAS, the NCJFCJ believes that judicial oversight means, at a minimum, that each court:

- Is aware of every child who is being prescribed psychotropic medications, and has the following information:
  - the names and dosages of all psychotropic medications being prescribed as well as all other medications being prescribed and taken,
  - the reason for the prescription(s),
  - the alternatives to medications that have been considered,
  - the other interventions that should accompany or are accompanying the use of the medications,
  - the actual effects of the medications, both beneficial and adverse,
  - the name of the medical professionals prescribing the medications and their qualifications, and
  - the individual responsible for administering the medication to the child.
- Ensures a qualified medical professional is timely and thoroughly monitoring the medications.
- Ensures there are protocols in place to maintain the medication regimen without interruption when any placement changes occur.
- Ensures parents are fully involved and informed about the use of the medications and the reason for their use, and have the ability to maintain the regimen or meaningfully decide, in consultation with medical professionals, whether and how to discontinue medications during reunification or upon return to their custody.

- Ensures all other caregivers are fully informed of the use of the medications and the reasons for them and have the ability to maintain the medication regimen in consultation with medical professionals.
- Ensures children have been engaged at the earliest possible time in the medication process, allowing the court to have an understanding of their attitude toward medications and whether additional services or resources will be necessary to assure medication compliance.
- Ensures all children transitioning from child welfare or juvenile justice who are being administered psychotropic medications have been educated sufficiently to maintain their medication regimen and make decisions about their care, including possible adverse effects of sudden discontinuation of psychotropic medications.

BE IT THEREFORE RESOLVED AS FOLLOWS:

NCJFCJ shall promote the exercise of judicial leadership to convene and engage States and other jurisdictions, communities, and stakeholders in the child welfare and juvenile justice systems in meaningful partnerships to encourage and to ensure, when necessary, the appropriate use of psychotropic medications for children and youth under court jurisdiction.

NCJFCJ is committed to development of technical assistance resources to assist judges in fulfilling the oversight role described in this resolution.

NCJFCJ is committed to educating judges on issues related to psychotropic medications, including but not limited to, the safe and appropriate use of psychotropic medications and recommended practices for judicial oversight.

NCJFCJ remains committed to educating judges on the substantial impact trauma can have on children and families and how psychotropic medications are most appropriately used when trauma is present.

NCJFCJ encourages engaging parents, caregivers, and others involved in the care, supervision and treatment of the child to be educated regarding the appropriate use of psychotropic medication for children.

NCJFCJ shall advocate for information sharing among those involved in the care and treatment of children under court jurisdiction and for the development and use of technology to enhance information sharing among all entities responsible for the care of children under court jurisdiction.

NCJFCJ supports the development of consultation resources for those courts that are charged with making decisions regarding the use of psychotropic medications for children under court jurisdiction.

NCJFCJ encourages the further study of, and the continued analysis of available data on, effective interventions and outcomes for children prescribed psychotropic medications with particular emphasis on disproportionately impacted populations.

Adopted by the NCJFCJ Board of Trustees during their Annual Meeting, July 13, 2013, Seattle, Washington.

DCFS HEALTH & MEDICATION GUIDE

Children and youth in foster care must receive education and training enabling them to make informed decisions about their health and mental health. For example, some children/youth have severe diabetes and cannot survive without insulin; and others take psychotropic medication for mood stabilization. It is critical that children and youth in foster care develop an understanding of their medical and/or psychiatric conditions, and know how to continue treatment, and access their medication in preparation for the day when jurisdiction is terminated over their case. Following are guidelines designed to prepare children and youth in foster care to make their own health and mental health decisions.

NOTE: Administration of medication by caregivers or self-administration by children/youth, must be in compliance with State of California Title 22 Community Care Licensing Regulations.

DCFS Goals & Milestones Guidelines		
Age		**Children and youth in foster care should have practical experience that allows them to reach the following goals/milestones regarding medication:**
0-3		Medications should be dispensed by the caregiver according to instructions on prescription label or as directed by the appropriate medical professional in accordance with Title 22 89475(c). Caregiver should familiarize themselves, via consultation with doctor and pharmacist, with the effects and side effects of medications and what to do in an emergency.
4-7		In addition to the above, using age appropriate language the caregiver should begin to teach the child the name, dose and frequency of the medication, as well as what symptom's it should relieve, so the child can begin to connect the type of medication with the effects (s)he experiences.
8-11		In addition to the above, once the physician of a child/youth has determined that the child/youth has sufficient maturity and gives permission, the child/youth may self-administer medication or injections in accordance with Title 22 89475.1. The caregiver should begin teaching the child/youth to be responsible for taking medications, e.g., use a series of check boxes or calendar or days-of-the week/AM-PM pill dispenser, so

DCFS Goals & Milestones Guidelines		
Age		**Children and youth in foster care should have practical experience that allows them to reach the following goals/milestones regarding medication:**
8-11		the child/youth can check off or track when (s)he took medication. The caregiver must closely monitor to ensure the child/youth takes the appropriate dose. **NOTE:** If a caregiver is uncomfortable with showing a child/youth how to self-administer the medication or injections, the caregiver may seek assistance from the licensed health care professional providing care to the child/youth. The caregiver may also arrange for a licensed health care professional to administer the medication or injections to the child/youth.
12-13		In addition to the above, youth knows which medications (s)he is taking and can articulate why.
14		In addition to the above, with the youth's consent, a trusted adult is identified (family, parent, caregiver, CSW, etc.) who can be made aware of the youth's medical needs.
15-17		In addition to the above, youth should start participating in scheduling their medical and mental health appointments, refilling prescriptions and being responsible for taking medication, with caregiver assistance.
18		In addition to the above, youth should: 1. Understand that even if (s)he remains under DCFS supervision, (s)he will be making her/his own decisions about health and mental health care. 2. Be making his/her own medical and/or mental health appointments and obtaining prescription refills, with caregiver "check-ins." 3. Have copies of health and mental health history, and know how to have it transferred to a new doctor, therapist, etc. This should include: • Contact information for Medical & Dental Health care provider(s) (primary care physician, etc.) • Contact information for Mental Health Care provider(s) (Psychiatrist, Therapist, etc.)

DCFS Goals & Milestones Guidelines	
Age	**Children and youth in foster care should have practical experience that allows them to reach the following goals/milestones regarding medication:**
18	• Medications(s) (List of current and past) • Immunization Record • Hospitalization(s) and why • Diagnosis list • Treatment Plan(s) • Evaluation(s) 4. Know how to access regular care and treatment (make appointments, transportation, Medi-Cal or other payment method, etc.) 5. If check-ups beyond an annual physical are needed, youth should know why, where and with whom (e.g., sickle cell disease check-ups are more frequent than annually). 6. Know about the medications prescribed, including: • List of medication(s) • Why it (each) is prescribed • The correct dosage and frequency • Side effects, "red-flags" and who to call in an emergency • How to refill prescriptions and obtain pharmacist consultation • How to make appointments to change or get new prescriptions • What to do if they wish to stop taking the medication and what the side effects might be

CSW Responsibilities

1. Therapeutic treatment that accompanies medication:
   - Collaborate with the caregiver or parent and health care provider to ensure that counseling, psychotherapy, physical therapy or other therapeutic services that the physician or psychiatrist has prescribed in the treatment plan are accessible.
   - Interview the caregiver and identify any barriers to obtaining medication and compliance with health/mental health treatment plan. Provide assistance in obtaining services to eliminate any identified barriers.

2. Psychotropic Medication Authorization (PMA) process:
   - When contacted by the health or mental health care provider, psychiatrist or physician; Public Health Nurse (PHN); D-Rate Unit staff; or Department of Mental Health Juvenile Court staff (DMHJC), provide information regarding observed behaviors of the child/youth (including reports from or contact with

school, law enforcement or Probation.) Refer to Policy Guide 0600-514.10, Psychotropic Medication: Authorization, Review and Monitoring for DCFS-Supervised Child.

3. Continuity of medication regimens when children/youth change placements:
   - Refer to Policy Guide 0300-503.97, Notice of Replacement Report for specific instructions.

4. Caregivers and parents understand the child/youth's need for medication and/or therapy:
   - Interview the caregiver or parent to confirm (s)he has discussed the child/youths diagnosis and treatment plan (including medication and/or therapy) with the appropriate providers, (e.g., physician, psychiatrist, pharmacist, therapist/counselor.) Refer to Policy Guide 0600-514.10, Psychotropic Medication: Authorization, Review and Monitoring for DCFS-Supervised Child.
   - Work with caregiver, trusted adult(s) and/or other relevant individuals (i.e., Wraparound staff, FFA or Group Home Case Manager, etc.) to ensure each understands the above goals/milestones and what role each will play in assisting the child/youth to reach those goals/milestones.
   - Inform the caregiver of Child Health and Disability Prevention (CHDP) Program and services. Refer to Policy Guide 0600-506.10, Child Health & Disability Prevention (CHDP) Program.

5. Child/youth understands what medications he or she is taking and why:
   - Using age appropriate language, interview the child/youth and confirm (s)he has had a discussion regarding his/her diagnosis and treatment plan (including medication and therapy) with the caregiver/parent and appropriate providers, (e.g., physician, psychiatrist, pharmacist, therapist/counselor.)
   - If children/youth are not meeting the goals/milestones or do not have the information regarding their health/mental health treatment, provide the caregiver or youth (as applicable) linkage to appropriate services. For children 0-17 years of age these may include (but are not limited to): regional center, child/youth mental health services, Wraparound and Full Service Partnership (FSP) Transition Age Youth (TAY). For youth 18 years of age or older linkage to adult services, such as regional center, adult mental health and FSP TAY. Collaborate with DMH, regional center workers or medical professionals to identify potential services, placements, etc.

6. Youth aging out (17 years and 5 months - 18 years old) or transitioning to Extended Foster Care (EFC) (Nonminor Dependents) have the ability to make decisions for themselves regarding health care and medication including psychotropic medication:
   - See goals/milestones section above, as well as the following Policy Guides and Form: 0100-535.60, Youth Development: The 90-Day Transition Plan and Transitioning to Independence; 0100-535.25, Extended Foster Care (EFC)

Program and; the DCFS 6009, Nonminor Dependent (NMD) Informed Consent form.

- Provide the complete Health & Education Passport (HEP) Binder to:
  - ☐ Youth who are aging out of foster care and whose jurisdiction is being terminated or;
  - ☐ Nonminor Dependent (NMD) youth who will no longer be participating in EFC and whose jurisdiction is being terminated or;
  - ☐ Nonminor Dependent (NMD) youth participating in EFC and residing in a Supervised Independent Living Placement (SILP).

  Refer to Policy Guide 0080-505.20, Health & Education Passport (HEP)

7. Documentation:
   - All of the above information gathered is to be documented in the appropriate CWS/CMS Contact Notebook and Health Notebook as appropriate. Additionally, all of the above information is to be documented in the Case Plan, Status Review Hearing Report and the 90-Day Transition Plan (when appropriate).
   - Inform the court and child/youth's attorney of the status of the goals/milestones via the Case Plan, each Case Plan Update and Status Review Hearing report.

DCFS D-Rate Unit Responsibilities:

- Complete the D-Rate Unit duties outlined in Policy Guide 0600-514.10, Psychotropic Medication: Authorization, Review and Monitoring for DCFS-Supervised Child. This includes contact with caregiver or parent regarding the child/youth's psychotropic medication needs and treatment.

Public Health Nurse (PHN) Responsibilities:

- Assist the CSW in obtaining provider cooperation in completing the DCFS 561(a)(b)(c), if needed. This includes discussion with the health/mental health care provider regarding documentation that the condition and treatment were explained to the caregiver and child/youth; whether or not the youth is authorized to self administer his/her own medication, and whether or not the self administration is to be supervised by an adult.
- Provide consultation to the CSW, as needed, for all children/youth with medical or psychiatric issues or concerns. Per existing procedure, the CSW submits the, DCFS 5646-1, Public Health Nursing Consultation Request. NOTE: Copies of the JV-223 are provided to the PHN's. Refer to Policy Guide 0600-530.00, Public Health Nurses (PHNs): Roles and Responsibilities.

Healthcare Provider (Medical/Dental/Psychological) Responsibilities:

- Completes the DCFS 561(a), (b) & (c) documenting whether or not:
  - ☐ Condition and treatment were explained to the caregiver and child/youth (as age appropriate);
  - ☐ Youth may self administer his/her own medication with adult supervision;
  - ☐ Youth is authorized to self administer his/her own medication.

DCFS HEALTH & MEDICATION GUIDE

Policy:

Policy Guides:	
0080-502.10	Case Plans
0080-505.20	Health & Education Passport (HEP)
0100-510.61	Placement Responsibilities
0100-535.25	Extended Foster Care (EFC) Program
0100-535.60	Youth Development: The 90-Day Transition Plan and Transitioning to Independence
0300-503.15	Writing a Status Review Hearing Report for a WIC Section 364, 366.21(e) or (f), 366.22 or 366.25 Hearing
0300-503.97	Notice of Replacement Report
0600-506.10	Child Health & Disability Prevention (CHDP) Program
0600-514.10	Psychotropic Medication: Authorization, Review and Monitoring for DCFS-Supervised Child
0600-530.00	Public Health Nurses (PHNs): Roles and Responsibilities
0700-500.10	Education of DCFS-Supervised Children

Forms:

DCFS 561(a), Medical Examination Form
DCFS 561(b), Dental Examination Form
DCFS 561(c), Psychological/Other Examination Form
DCFS 5646-1, Public Health Nursing Consultation Request
DCFS 6009, Nonminor Dependent Informed Consent

Children's Law Center of California

MEMORANDUM

TO: **Psychotropic Medication Committee**
FROM: **Children's Law Center of California**
DATE: **October 20, 2017**
RE: **Policy Recommendations to Promote Medical Decision-Making Readiness - Revised**

Dependents and wards must have the tools to make informed decisions about their health and mental health by the time they reach adulthood. For example, some child clients have severe diabetes and cannot survive without their insulin; others take psychotropic medication to maintain successful functioning. It is critical that these clients develop an understanding of their medical conditions, and know how to continue treatment and access medication, prior to reaching adulthood. Below are initial policy recommendations that can help to better prepare dependents and wards to make informed medical decisions by the time they reach age 18.

All youth taking medication should be engaged in regular conversation about medication they are taking, why they are taking it and how they feel about taking the medication. Policy and practice should ensure that youth gain practical experience making medical decisions and are empowered to reach certain milestones as outlined below. The individuality of each client and relevant developmental and emotional stages may impact the achievement of these goals.

- ✓ By age 14, the youth should be able to articulate what medications s/he is taking and why, as well as how s/he feels about taking the medication.
- ✓ By age 15, the youth should be able to identify a trusted adult (family member, parent, caregiver, social worker, CASA, mentor, etc.) who they can make aware of their medical needs and who can assist them with their ongoing medical care if necessary. CSW should facilitate a meeting with the youth and the identified adult to discuss and share current medical and mental health information.
- ✓ By age 16, the youth should be aware of when they are to take the medication prescribed, any conditions necessary for them to take the medication as prescribed, and any contraindications relevant to each medication. The youth should be encouraged to share the responsibility with a caregiver or trusted adult to make sure that prescriptions are filled in timely manner and that medication is taken at the prescribed time.

- ✓ By age 17.5, the youth should make medical and mental health appointments and refill prescriptions, initially with the assistance of a caregiver or trusted adult, and later, independently.

- ✓ By age 18, the youth should:

  1. Understand that even if the case is open, s/he will be making decisions about his or her own health and mental health.

  2. Maintain copies of their health and mental health history to include:

     - Contact information for current doctors, therapists psychiatrists and other health professionals
     - Access to their medical history including medications, history of hospitalizations and diagnoses
     - A copy of their DCFS Health and Education Passport

  3. Schedule medical and mental health treatment appointments.

  4. Know any and all medications prescribed, including:

     - The name of the medication(s)
     - The reason it is prescribed
     - The correct dosage
     - Potential side effects
     - Names and contact information for prescribing medical providers

  5. Work with their therapeutic team to revise their treatment plan, as needed, to reflect their treatment decisions as well as to:

     - Understand how to talk with their health care provider about changing or stopping medication
     - Understand the possible side effects of changing or stopping medication
     - Discuss the addition of alternative services to counterbalance the discontinuation of medication.

RESPONSIBILITIES

Children's Law Center of California

1) Collaborate with CSW/PO to ensure that youth have the opportunity to meet the goals/milestones identified above and are receiving the information, support and practice opportunities necessary to be able to do so.

2) Communicate with youth about the significance of consenting to medical treatment.
3) Bring to the court's attention any concerns.

CSW/Probation Officer

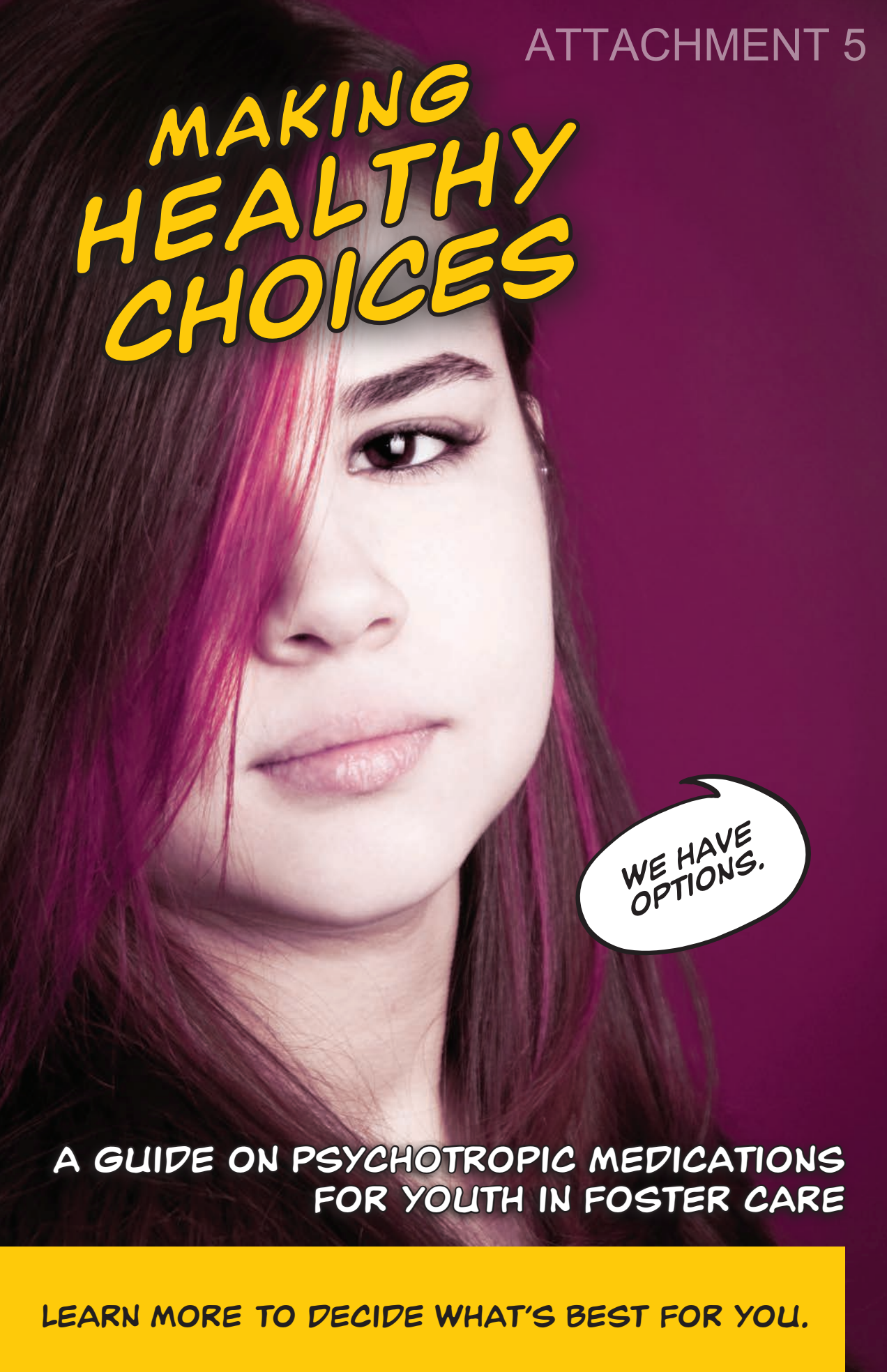
1) Identify goals/milestones in the case plan or TILP.
2) Work with caregiver, trusted adults and/or other relevant individuals (i.e. wraparound, FFA or group home case manager, etc.) to ensure they understand the goals/milestones and what, if any, role they will play in assisting the youth to reach those goals/milestones.
3) Assist youth in working with treating physician to ensure they are receiving the information detailed above.
4) If youth are not meeting the goals/milestones or do not have the information detailed above, provide linkage to adult services, such as regional center, adult mental health & systems of care. Collaborate with adult DMH, regional center workers or medical professionals to identify potential services, placements, etc
5) Inform the court and counsel of the status of the goals/milestones in court reports.

Court

1) Ensure case plan/TILP identifies appropriate goals/milestones, and that youth are receiving assistance to meet such goals/milestones.

ATTACHMENT 5

MAKING HEALTHY CHOICES



A GUIDE ON PSYCHOTROPIC MEDICATIONS FOR YOUTH IN FOSTER CARE

LEARN MORE TO DECIDE WHAT'S BEST FOR YOU.

MAKING HEALTHY CHOICES: A GUIDE ON PSYCHOTROPIC MEDICATIONS FOR YOUTH IN FOSTER CARE

2012

THE CONTENTS OF THIS GUIDE ARE FOR INFORMATIONAL PURPOSES ONLY AND DO NOT SUBSTITUTE FOR PROFESSIONAL MEDICAL ADVICE.

DOING WHAT YOU CAN TO FEEL YOUR BEST

Everyone can benefit from learning what to do to be healthy. Young people in foster care have a lot of stressful things to deal with in their lives. Often they hurt a lot inside. Sometimes their coping skills are overwhelmed. They may need extra help in figuring out how to handle their feelings and improve their health.

Teens who are sad or angry may feel better if they talk to someone they trust, do a favorite hobby, or exercise or play sports. Youth who feel really bad or act in unexpected ways often need help and support from other people. Sometimes, they need therapy and/or medication that can help them control their emotions and behaviors.

When you're hurt, there are often several things you can do to feel better. Imagine you fall and hurt your ankle—you can take a pain reliever, avoid walking on it, and/or apply ice. In the same way, when you hurt a lot inside, you can take medication, avoid activities that make the condition worse, and/or look for positive activities that help you balance your feelings.

WHAT'S IN THIS GUIDE?

Making decisions about your health and psychotropic medications involves several steps, shown in the arrows below. This guide presents valuable information for youth in foster care related to each step. Depending on your situation, selected sections or the entire guide may be useful to you. The guide's checklists and worksheets can help you organize your thoughts.

PAGE 1

PAGE 7

PAGE 10

PAGE 13

PAGE 18

READ ON TO LEARN MORE...

WHY READ THIS GUIDE?

This guide can help you figure out if certain medications are right for you. It was created by a group of youth who have experienced foster care, doctors, social workers, and others who care about young people.

Sometimes your thoughts, emotions, or behaviors get in the way of doing things you want to do. Maybe you're not able to sleep at night or do your homework or have fun with friends. This guide talks about psychotropic medications—one option that may help you feel better. These medications can have many benefits. They also can cause negative side effects and can be harmful if not used correctly. Once you know more, you can decide whether these medications are a good option for you.

WHAT ARE PSYCHOTROPIC MEDICATIONS?

PSYCHOTROPIC (PRONOUNCED "SIKE-OH-TROPE-ICK") MEDICATIONS AFFECT A PERSON'S ***MIND***, ***EMOTIONS***, ***MOODS***, AND ***BEHAVIORS***. DOCTORS PRESCRIBE THESE DRUGS TO HELP PEOPLE FOCUS ON SCHOOL OR WORK AND ENJOY THEIR LIVES MORE.

#1

RECOGNIZING YOU NEED HELP

HOW DO I KNOW IF I NEED HELP?

Young people in foster care are often struggling with past trauma and loss, lots of changes, and issues with family, friends, or their placement. Sometimes, the feelings that result can become overwhelming or even result in depression, anxiety, or stress symptoms that need to be treated with medication.

It's not always easy to know when you should seek help from a doctor, counselor, or teacher. Everyone has bad days from time to time. Most days should not be bad days.

Signs that you may need help include:

- You have symptoms that occur most days.
- You experience a big change in how you feel.
- Your symptoms get in the way of school, your job, or your relationships.
- Your actions are dangerous.

If you see signs that you need help, talk to trusted adults (an advocate, mentor, or caseworker) about getting an appointment with a doctor or mental health specialist.

MICHAEL'S GRADES DROPPED WHEN HE CHANGED SCHOOLS. HE HAD TROUBLE SITTING STILL AND PAYING ATTENTION IN CLASS. FRUSTRATED, HE BEGAN SKIPPING CLASSES. WITH MICHAEL'S INPUT, HIS PLANNING TEAM DEVELOPED A TREATMENT PLAN OF MEDICATION, MEETING WITH A SUPPORT GROUP, AND WRITING IN A JOURNAL. OVER TIME, MICHAEL FELT MORE RELAXED AND COULD FOCUS BETTER IN SCHOOL. HE HAS STARTED WRITING SHORT STORIES AND THINKING ABOUT COLLEGE.

WHAT IS A SYMPTOM?

A SYMPTOM IS SOMETHING YOU EXPERIENCE THAT MAY BE A SIGN OF SOMETHING MORE SERIOUS. FOR EXAMPLE, A TOOTHACHE CAN BE A SYMPTOM OF A CAVITY. THE FOLLOWING MAY BE SYMPTOMS OF DEPRESSION: NOT BEING ABLE TO PAY ATTENTION, LACK OF ENERGY, HEADACHES, AND CONSTANT FEELINGS OF HOPELESSNESS AND SADNESS.

SYMPTOM CHECKLISTS

Use the following checklists to help you record the ways you're feeling and behaving.[1] The symptoms checklists can help organize your concerns to discuss with a doctor or counselor. You also may choose to use the checklists to talk with other people in your life about what you're experiencing and what they've noticed.

Read through each checklist item and think about how often you experience each symptom. While the lists may seem long, they should take only a few minutes to complete. **It's a good idea to bring these checklists with you when you visit your doctor, nurse, or mental health specialist**.

PHYSICAL SYMPTOMS			
	Never	Sometimes	Often
I have headaches			
I have stomachaches			
I get rashes or other skin irritations			
I get tired easily			
I have trouble sleeping			
I sleep too much			
I have problems seeing clearly			
I have problems hearing clearly			
Other:			

	Yes	No
I've recently gained a lot of weight		
I've recently lost a lot of weight		

1 Checklists adapted from *Team Up for Your Child: A Step-by-Step Guide for Working Smarter With Doctors, Schools, Insurers, and Agencies.* (2008). Oak Ridge, TN: Melton Hills Media. Checklists adapted with permission of author Wendy Lowe Besmann.

BEHAVIORS AT SCHOOL, WORK, AND HOME			
	Never	Sometimes	Often
I lose my things (school books, lunch, jewelry, etc.)			
I have trouble getting organized			
I have trouble paying attention			
I have trouble sitting still or doing quiet activities			
I have trouble stopping one activity and starting another activity			
I start many projects without finishing them			
I have difficulty waiting my turn			
I act impulsively (quickly without thinking)			
I argue with people in charge (teachers, bosses, caseworkers)			
I'm afraid to go to school or I skip school			
I talk too much or too fast			
I must follow fixed routines (do things in the same way every time)			
I pull out my hair (from my head or other parts of my body)			
Other:			

	Yes	No
My grades have dropped a lot recently		

SYMPTOMS RELATED TO RELATIONSHIPS			
	Never	Sometimes	Often
I fight with kids my age (peers)			
I have little interest in spending time with friends			
I have trouble making or keeping friends			
Other:			

SYMPTOMS RELATED TO FEELINGS			
	Never	Sometimes	Often
I feel sad or "lost"			
I feel anxious, very worried, or stressed			
I'm easily frustrated			
I get really angry and have outbursts (throw things, yell)			
I blame others for my mistakes or behaviors			
My feelings change very quickly (for example, I'm laughing and happy and then quiet and sad)			
I'm afraid to try new things because I may make mistakes			
I'm really concerned with my weight			
I feel lonely and depressed			
I feel that my life is worthless			
I feel that no one loves me or cares about me			
I think about wanting to die			
Other:			

SYMPTOMS RELATED TO RISKY BEHAVIORS			
	Never	Sometimes	Often
I lie or "con" others to get out of trouble, avoid things, or get things I want			
I've deliberately set fires			
I've been cruel to animals			
I bully or threaten others			
I've hurt others on purpose			
I've used a weapon to harm a person, animal, or property			
I've run away or stayed out all night without permission			
I've committed crimes			
I abuse drugs or alcohol			
I physically hurt myself (cutting)			
I have sex to gain approval from others or to feel better about myself			
Other:			

SEEK IMMEDIATE HELP FROM A DOCTOR, MENTAL HEALTH PROFESSIONAL, OR EMERGENCY ROOM IF:

- YOU'RE THINKING ABOUT HURTING YOURSELF OR ATTEMPTING SUICIDE.
- YOU'RE THINKING ABOUT HURTING SOMEONE ELSE.
- YOU'VE BEEN FEELING DEPRESSED, HOPELESS, OR WORTHLESS FOR SEVERAL DAYS AND HAVE BEEN UNABLE TO TAKE CARE OF YOURSELF.
- YOU'RE HEARING OR SEEING THINGS THAT OTHERS DO NOT HEAR OR SEE.

GETTING A PROFESSIONAL ASSESSMENT

If you are having symptoms that are a problem for you, you should meet with your regular doctor to get the medical help you need. Your doctor will do an assessment that may include asking you a lot of questions, conducting a physical exam, and doing some laboratory work to identify any medical problems. The doctor will then work with you to figure out what might help you feel better.

You and your doctor may decide that it is important to get additional help. For example, sometimes doctors refer patients to a mental health specialist for a full evaluation.

Assessments and evaluations are chances for you to learn more about:

- **Your concerns or symptoms**—Are there reasons for why you feel or behave the way you do?
- **A diagnosis**—Is there a name for what is making you feel or behave the way you do?
- **Recommended treatment**—What does the doctor suggest you do?
- **Options**—Will taking medication help you feel better? What else might help? (Options may include getting help in school, talking with a counselor, or learning strategies for dealing with your feelings and behaviors.)

#2

KNOWING YOUR RIGHTS AND WHO CAN HELP

WHAT ARE MY RIGHTS?

Youth in foster care have legal rights related to health care and medication.

YOU HAVE THE RIGHT TO...

- ☐ **Get a good assessment** in which a doctor or specialist meets with you, listens to you, and discusses options.
- ☐ **Know your diagnosis** and understand the name and nature of what makes you feel and behave the way you do.
- ☐ **Find out all of your options** for treatment, including alternatives to medication. (See page 10.)
- ☐ **Ask questions** about the benefits and side effects of any medication a doctor suggests you take. (See sample questions on pages 14–15.)
- ☐ **Receive support from a planning team** to help you with medical decisions. (See page 8.)
- ☐ **Know who has permission to make decisions** about medications for you. (This may differ according to each State's law.)
- ☐ **Ask an adult you trust for help** in understanding your rights to accept or refuse medication and to ask for changes in your treatment plan.

WHAT IS INFORMED CONSENT?

CONSENT MEANS TO GIVE PERMISSION FOR SOMETHING TO HAPPEN. THROUGH *INFORMED CONSENT*, A DOCTOR PROVIDES INFORMATION ABOUT THE RISKS AND BENEFITS OF A PARTICULAR MEDICATION OR TREATMENT BEFORE PERMISSION IS GIVEN FOR THE MEDICATION TO BE USED. FOR YOUNG PEOPLE WHO ARE NOT IN FOSTER CARE, THEIR PARENTS USUALLY MAKE DECISIONS ABOUT MEDICATION. FOR YOUNG PEOPLE IN FOSTER CARE (OR STATE CARE), EVERY STATE HAS DIFFERENT LAWS AND POLICIES THAT DETERMINE WHO CAN GIVE PERMISSION FOR MEDICATION. AS YOUTH GET OLDER, THEY ARE INCLUDED IN DECISION-MAKING AND GIVING THE "GO AHEAD." (ASK YOUR CASEWORKER ABOUT WHO CAN GIVE CONSENT OR PERMISSION FOR MEDICATION IN YOUR STATE.)

WHO CAN HELP ME MAKE DECISIONS?

You play a key role in decision-making about your health. You're not alone in making health-care decisions. Several people can help you, including those suggested on the worksheet on the next page.

YOUR PLANNING TEAM

A PLANNING TEAM IS A GROUP OF PEOPLE THAT PROVIDE YOU WITH INPUT AND GUIDANCE ON MEDICAL CARE. THE PLANNING TEAM (IF YOU HAVE ONE) MAY INCLUDE YOUR:

- CASEWORKER
- BIRTH PARENTS, SIBLING, OR OTHER FAMILY MEMBERS (IF THEY ARE INVOLVED IN YOUR MEDICAL CARE)
- FOSTER PARENT OR GUARDIAN
- ADVOCATE, MENTOR, OR ANOTHER TRUSTED PERSON OF YOUR CHOICE
- FRIENDS
- ATTORNEY
- GUARDIAN *AD LITEM* (GAL) OR COURT-APPOINTED SPECIAL ADVOCATE (CASA)–PEOPLE ASSIGNED BY A JUDGE TO LOOK OUT FOR YOUR BEST INTERESTS WHILE IN FOSTER CARE
- DOCTOR, NURSE, OR OTHER MEDICAL PROVIDER WHO HELPS WITH PHYSICAL HEALTH CARE
- HEALTH- OR MENTAL HEALTH-CARE PROVIDER WHO PRESCRIBES MEDICATIONS TO HELP BALANCE MOODS AND BEHAVIORS

WORKSHEET ON WHO CAN HELP MAKE DECISIONS

Fill in the table with names of people you feel you can talk to for support and guidance.

Caseworker	
Name	
Phone	
Email	
Birth parent, sibling, or other family members	
Name	Name
Phone	Phone
Email	Email
Foster parent or guardian	
Name	
Phone	
Email	
Advocate, mentor, or another trusted person of your choice	
Name	
Phone	
Email	
Friend	
Name	
Phone	
Email	
Attorney, guardian *ad litem* (GAL), or court-appointed special advocate (CASA)	
Name	
Phone	
Email	
Doctor, nurse, or other medical professional who helps with physical health care	
Name	Name
Phone	Phone
Email	Email
Health- or mental health-care provider who prescribes medications to help balance moods and behaviors	
Name	
Phone	
Email	

#3 CONSIDERING YOUR OPTIONS

WHAT ARE MY OPTIONS?

Your doctor or mental health specialist may discuss several options with you. These options may include:

Helpful approaches other than medication

Psychotropic medication for temporary or long-term use

A combination of the above

OPTIONS OTHER THAN MEDICATION

Sometimes there are treatments that can be used instead of or in addition to medication.

- **Counseling/therapy.** It's always good to have trusted friends and family to talk with about your problems. Sometimes that's not enough. In those cases, you may want to talk with a trained therapist who can listen and offer guidance. The therapist can help you learn useful ways to deal with your feelings. An adult on your planning team can help you find a therapist.
- **Meditation.** Meditation is a type of mental exercise in which you learn to relax your body and calm your mind. Meditation is known to reduce stress and can help improve concentration. It can bring inner peace by helping you control your thoughts and become more aware. Meditation is a skill that requires learning and practice. A workshop or class can help get you started.
- **Exercise.** Exercise releases endorphins, or "feel-good" chemicals, in your brain. These chemicals make you feel less sad or anxious. Being active can take your mind off your problems and improve your ability to deal with things. You can exercise alone, join a team, or organize some friends. Look for physical activities that you enjoy—hiking, dance, basketball, or other—and make exercise fun.

- **Diet.** What you eat may affect your moods and energy levels. You may feel better eating less "bad carbs," including foods with lots of sugar or white flour (muffins, white bread, bagels). Research tells us to eat foods rich in healthy omega-3 fats, which can be found in nuts and certain fish (tuna, salmon). Vitamins and minerals also can help your brain and body work better. Before taking vitamin supplements or making changes in your diet, talk with your doctor.
- **Other activities.** There may be other ways to help you feel better, such as:
  - Keeping a journal of what's going on in your life and how you feel about things
  - Drawing, painting, or other art work
  - Joining a club
  - Participating in a support group of other youth in similar situations
  - Volunteering and helping others

AFTER BEING SEPARATED FROM HIS MOTHER AND LITTLE BROTHER, TONY LASHED OUT AT THOSE AROUND HIM. HIS MIND WAS RACING ON OVERDRIVE. AFTER TALKING WITH HIS DOCTOR AND A YOUTH COUNSELOR, HE DECIDED MEDICATION WASN'T FOR HIM. INSTEAD, HE STARTED MEETING REGULARLY WITH A THERAPIST, WHO HELPED HIM SORT THROUGH HIS ANGER. JOINING THE SCHOOL'S FOOTBALL TEAM ALSO HELPED CHANNEL HIS ENERGIES.

PSYCHOTROPIC MEDICATIONS

Psychotropic medications can help people be healthy. Some medications may affect how you feel, and some may change behaviors that get in the way of your well-being. They can help you focus on things you want to do—like staying in school, holding a job, and enjoying time with friends. They may help you feel more in control and more satisfied with your life.

Doctors prescribe these medications to reduce symptoms such as anxiety, difficulties paying attention, and racing thoughts. They also are used to treat conditions including attention-deficit hyperactivity disorder (ADHD), depression, psychotic disorders, and others.

While psychotropic medications can have many benefits, they also may have side effects. Side effects are unwanted changes that occur in addition to the intended positive effects. Side effects vary from medication to medication and person to person. Some possible side effects of psychotropic medications include sleepiness, stomach upset, headaches, nervousness, irritability, and weight gain. Often, side effects will go away within a few weeks. You may decide that it's worth putting up with side effects, if the benefits outweigh them.

There is a risk of medications causing harm if not used correctly. Safe use of psychotropic medications is discussed in the section on maintaining treatment (page 18).

ANITA THOUGHT MOVING IN WITH HER GRANDMOTHER WOULD MAKE HER LIFE BETTER, BUT SHE STILL FELT WORRIED ALL THE TIME. SOME DAYS, IT SEEMED DIFFICULT JUST TO BREATHE. SCARED HER FRIENDS WOULDN'T UNDERSTAND, SHE BEGAN TO AVOID THEM. ON THE ADVICE OF HER DOCTOR, SHE FOUND A MEDICATION THAT HELPED HER FEEL BETTER. SOON, IT WAS EASIER TO MAKE IT THROUGH THE DAY. SHE BEGAN LOOKING FORWARD TO HAVING FUN WITH HER FRIENDS AGAIN. OVER TIME, HER DOCTOR HELPED HER TO GRADUALLY STOP TAKING THE MEDICATION AND IDENTIFY OTHER WAYS TO DEAL WITH HER ANXIETY.

#4 MAKING YOUR DECISION

WHAT INFORMATION DO I NEED?

There is a lot of information you should have before taking medication. Below is a list of questions to help guide you in making decisions about how best to stay healthy. You may have more questions than you see here.

Take these questions with you when you talk about your health with the adults in your life. Remember, answers to these questions and your decisions may change over time.

QUESTIONS TO ASK YOURSELF
...ABOUT BEING HEALTHY:

- ☐ What are some things that I could do to be healthy? (For example, change my diet, get more sleep, see a counselor, take medication)
- ☐ What do I already know about how each option (including medication) might help me? How might they harm me?
- ☐ How long would I need to do each of these things?
- ☐ How will I know when I'm healthy?
- ☐ Who can help me make the right decision for me?

QUESTIONS YOU MAY ASK AN ADVOCATE, MENTOR, OR OTHER ADULT
...ABOUT YOUR RIGHTS:

- ☐ Who has the right to make decisions about my taking medication?
- ☐ Can a decision be made without me saying what I want? If that happens, what right do I have to speak to the person who made the decision (such as the judge or caseworker)?
- ☐ Do I have a right to refuse to take medication?
- ☐ If I refuse to take medication, what will happen? Can I be punished? Can I be asked to leave my placement?

CONTINUED...

- ☐ If I disagree with a decision about medication or my medical care, what can I do or who can I call? Should I speak with my attorney or guardian *ad litem*?
- ☐ Does my State have someone, such as an ombudsman (pronounced om-budz-man), who investigates complaints and helps youth in foster care?
- ☐ If I disagree with a decision about medication, do I have the right to get a second opinion from another doctor? How do I get a second opinion?
- ☐ Who else should know that I'm taking medication? What do they need to know and why?
- ☐ Who will find out that I've taken this medication? Can it make it harder to get a job or join the military if I take this medication?
- ☐ Can I see my medical records? Can I have a copy?
- ☐ Who pays for my health-care expenses while in foster care?
- ☐ How will I pay for health-care expenses when I leave foster care? Who can help me with medication decisions and payments once I leave care?

QUESTIONS TO ASK YOUR DOCTOR

...ABOUT GENERAL INFORMATION ABOUT A MEDICATION:

- ☐ What is my diagnosis?
- ☐ Do you recommend medication? What is the name of the medication you recommend?
- ☐ How much do I have to take and how often? (this is called "dosage")
- ☐ How long will I have to take the medication?
- ☐ How will I know it is working? When will it start working?
- ☐ How common is it for people my age to be on this medication?
- ☐ How much experience do you have with this medication?

...ABOUT HOW THE MEDICATION MAY CHANGE YOUR LIFE:

- ☐ How will this medication make me feel?
- ☐ How will using this medication change the way I act at school? How will it change the way I act or feel around family or friends?
- ☐ How can this medication help me achieve my goals in life?

...ABOUT THE SIDE EFFECTS OF THE MEDICATION:

- ☐ How might this medication harm me?
- ☐ What are the medication's side effects? How long do side effects typically last?
- ☐ Will the medication cause me to gain weight? Will I lose weight? Is there anything I can do to keep my current weight while taking the medication?
- ☐ Is this medication addictive (hard to give up once started)?
- ☐ What are the effects if the medication is taken with alcohol, marijuana, or other drugs?

...ABOUT USING THE MEDICATION SAFELY:

- ☐ What do I do if a problem develops (I get sick, I miss taking the medication, or I get side effects)?
- ☐ Are there foods I should avoid while on the medication? Are there special things I should or should not do while taking the medication?
- ☐ Will I need blood work or other kinds of medical tests before, during, or after treatment? What will the doctor look for?
- ☐ What do I do if I start taking the medication and then decide I don't like it? Who do I talk to?
- ☐ If I want to, can I just stop taking the medication?
- ☐ How often should I see the doctor (or other person) who prescribed the medication?
- ☐ Who will help me keep track of how the medication is working for me? How will changes be monitored?
- ☐ Who can I talk to about medication other than my doctor? Who needs to know I'm on this medication and why?

...ABOUT ALTERNATIVES AND OPTIONS:

- ☐ What other medications might help me?
- ☐ What alternatives to medication (meditation, changes in diet, exercise, etc.) might help me?
- ☐ Should I try other things that might help me at the same time as the medication?

WHAT ARE THE RISKS AND BENEFITS?

Based on what you've learned, you can use this worksheet to write down the pros (benefits) and cons (negatives) of taking medication.[2] You can discuss your hopes and concerns for this medication with adults who are helping you make your decision.

PROS AND CONS WORKSHEET

If I DO take the medication—*What does my doctor (or other decision-making supports) say about taking the medication*?

Pros/Benefits	Cons/Side Effects

If I DON'T take the medication—*What does my doctor (or other decision-making supports) say about NOT taking the medication*?

Pros/Benefits	Cons/Side Effects

2 Adapted from *Making a Choice: A Guide to Making A Decision About Using Antipsychotic Medication* by Youth MOVE Maine (http://www.youthmovemaine.org), Maine's Youth Leadership Advisory Team (http://www.ylat.org), and Maine Department of Health and Human Services. Available from http://www.ylat.org/rights/medication.pdf.

WILL MEDICATION HELP ME REACH MY PERSONAL GOALS?

You may want to think about how medication might help you achieve your life goals.[3] For example, if your goal is to go to college, medication may help you to concentrate in school and improve your grades. In some cases, medication or medication side effects may make it harder to reach your goals. Share your goals with your doctor so he/she understands what you want to achieve.

GOALS WORKSHEET
Use this worksheet to write about your goals—things you want to achieve in life.
In the next 3 months, my goals are to:
In the next 2 years, my goals are to:
If I could look into a crystal ball and see myself 5 years from now, what do I hope for?
How could medication help me reach my goals?
How might medication or medication side effects create challenges for reaching my goals?

3 Adapted from *Making a Choice: A Guide to Making A Decision About Using Antipsychotic Medication* by Youth MOVE Maine (http://www.youthmovemaine.org), Maine's Youth Leadership Advisory Team (http://www.ylat.org), and Maine Department of Health and Human Services. Available from http://www.ylat.org/rights/medication.pdf.

#5 MAINTAINING TREATMENT

HOW DO I MAKE SURE I'M TAKING MY MEDICATION SAFELY?

To increase the benefits and reduce the risks of using psychotropic medication, you need to be an active member of your health-care team.

It is important to:

- **Ask questions.** Talk with your doctor, nurse, pharmacist, and other health-care providers about your medications. Know what each medication is for, how to take it, what kinds of side effects to expect, and what actions might help reduce the side effects. (See sample questions beginning on page 14.)
- **Follow the directions on the label.** Take the medication exactly as prescribed.
- **Learn about what things don't mix well with your medication.** Some medicines, foods, and drinks should not be taken together. When mixed, they may reduce the positive effects of your medication or cause harmful effects. For example, drinking alcohol while taking medication can slow your reactions and make driving a car dangerous. Some herbs and supplements can interact with prescription medications in unsafe ways. Also, some medical conditions (such as high blood pressure) can cause unwanted reactions with certain medications. Talk with your doctor or pharmacist and read medication labels to learn more about what you should avoid when taking your medication.
- **Keep records.** Make an up-to-date list—on paper or your phone—of ALL medicines (prescription and over-the-counter) that you take, as well as vitamins, herbs, and other supplements. Make notes on how each medication makes you feel, side effects, and changes over time.
- **Follow up with your doctor regularly.** Throughout the time you are taking your medication, your doctor(s) should follow up with you, listen to your concerns, and monitor your progress.

DO NOT SHARE YOUR MEDS!

YOUR PSYCHOTROPIC MEDICATION IS INTENDED TO BE USED BY YOU AND ONLY YOU. GIVING YOUR MEDICATION TO SOMEONE ELSE COULD RESULT IN SERIOUS SIDE EFFECTS AND EVEN DEATH.

PREVENT BREAKS IN YOUR MEDICATION.

TIP: DON'T WAIT UNTIL YOU RUN OUT OF MEDICATION BEFORE YOU ASK FOR A REFILL. ADD A REMINDER TO YOUR CALENDAR OR PHONE TO CHECK YOUR SUPPLY AND CALL FOR A REFILL. IN SOME CASES, YOU MAY BE REQUIRED TO HAVE A DOCTOR'S APPOINTMENT IN ORDER TO GET A REFILL.

WHAT IF I WANT TO STOP TREATMENT?

Always talk with your doctor if you are thinking about stopping your medicine. You and your doctor should make this very important decision together. When you suddenly stop taking certain medications, you may experience uncomfortable or harmful side effects. These medicines have to be decreased slowly over several weeks. When you and your doctor agree that it is time to stop a medication, it is very important that you follow your doctor's instructions about how to do this.

Get rid of unused medication carefully. Make sure that other people and animals can't take and be harmed by leftover pills.

For more information, read *Disposal of Unused Medicines: What You Should Know*. http://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm186187.htm

SONYA DIDN'T LIKE HOW HER MEDICATION MADE HER FEEL TIRED AND UNABLE TO CONCENTRATE. SHE WANTED TO STOP TAKING IT. INSTEAD, SHE MET WITH HER DOCTOR AND TALKED ABOUT CHANGING TO A NEW MEDICINE THAT DIDN'T HAVE THE SAME SIDE EFFECTS.

WHAT SHOULD I DO ABOUT MEDICATION WHEN I'M LEAVING FOSTER CARE?

If you're getting ready to leave foster care, there are a few important things for you to do:

1. **Meet with your caseworker to develop a plan.** The law requires your caseworker to meet with you at least 90 days before you turn 18 (or before you are scheduled to leave foster care) to develop a transition plan. The plan should discuss ways to meet your needs for:

   - Lifelong connections to caring and supportive adults
   - Mental health and medical services
   - Health-care insurance coverage
   - Housing
   - Education
   - Employment

   You have the right to invite a mentor or other trusted adults to this meeting to help develop a plan that best meets your needs.

2. **Think about whether you want to continue your medication.** At the meeting with your caseworker and other trusted adults, discuss your wishes and concerns. Find out what your doctor(s) recommend.

   - **If you want to continue taking your medication:**
     Talk to your caseworker before leaving foster care about who can help you get and pay for future medication.
   - **If you want to stop taking your medication:**
     Talk to your doctor about how to decrease the dosage gradually.

3. **Get a copy of your medical records.** You should receive a free copy of your medical records. This is required by law when you're leaving foster care at 18 (or the age of majority in your State.) You may need some information from these records for future health care and also for college and job applications.

   Make sure your medical records include information on:

   - The name(s) of your doctor(s) and other health-care providers
   - Major illnesses, medical conditions, and injuries and the services provided to address them
   - Medications taken (psychotropic and others), when taken, when stopped, and why
   - Undesirable reactions to medication (if applicable)
   - Allergies
   - Immunizations
   - Growth records
   - Biological family history of major medical conditions (if known)

4. **Look into health insurance.** Health care can be expensive. There are some ways to get free or low-cost health care, including:

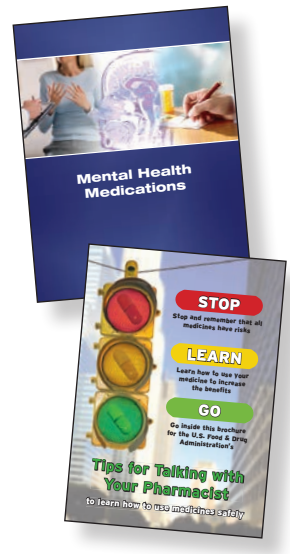
   - **Medicaid.** Many States offer continued health insurance for former foster youth through the Medicaid program. (Note: Medicaid coverage is only available until you reach a certain age, often 19 or 21.) To get continued health insurance, you often have to **make arrangements before you leave foster care**. Work together with your caseworker (or other adult) to complete the necessary paperwork. Make sure you find out what you will need to do on your own to continue coverage.
   - **Community health centers.** Federally funded health centers care for you, even if you have no health insurance. You pay what you can afford, based on your income. You can find a health center near you on the web at http://findahealthcenter.hrsa.gov.
   - **Student health centers.** If you're in college, you may be able to access health care through your school's student health center.

   Talk about these and other options with your caseworker.

NOW WHAT?

LEARNING MORE IS AN IMPORTANT FIRST STEP. CONTINUE TO ASK QUESTIONS AND TALK WITH YOUR DOCTOR(S) AND OTHER TRUSTED ADULTS. TOGETHER, YOU CAN FIGURE OUT WHAT MAKES THE MOST SENSE FOR A HEALTHY YOU.

To learn more about possible side effects and taking your medication safely, read the following online publications:



- *Mental Health Medications*. National Institute of Mental Health. http://mentalhealth.gov/health/publications/mental-health-medications/complete-index.shtml
- *Stop—Learn—Go. Tips for Talking With Your Pharmacist to Learn How to Use Medications Safely.* U.S. Food and Drug Administration. http://www.fda.gov/Drugs/ResourcesForYou/ucm163330.htm

WHAT DID I LEARN? WHAT ELSE DO I NEED TO KNOW?

Use this space to make notes that will help you think through your decisions about taking medication and other options to improve your health.

ACKNOWLEDGMENTS

This guide was developed through a collaborative committee of many young people and professionals, including individuals from:

- Children's Bureau, U.S. Department of Health and Human Services
- Administration for Children and Families, U.S. Department of Health and Human Services
- American Academy of Child and Adolescent Psychiatry
- American Academy of Pediatrics
- Food and Drug Administration, U.S. Department of Health and Human Services
- Jim Casey Youth Opportunities Initiative
- Maine Department of Health and Human Services
- Maine Youth Leadership Advisory Team
- National Resource Center for Youth Development
- Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
- Tufts Medical Center
- Youth MOVE Maine

The contents of this publication do not necessarily reflect the views, opinions, or policies of these agencies.

The committee acknowledges the work of Child Welfare Information Gateway, a service of the Children's Bureau, for the design and editing of the guide. We thank the National Resource Center for Youth Development for hosting the guide on their website. The committee also thanks the many young people and professionals who completed a field test and provided feedback; your assistance has been invaluable.

Children's Bureau

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau
http://www.acf.hhs.gov/programs/cb

Psychotropic Medication Youth Engagement Worksheet

	YES	NO	COMMENTS (as needed)
1. Does the youth know the name of the medication(s) being taken?	☐	☐	
2. Does the youth know the reason for the medication(s)?	☐	☐	
3. Does the youth know his or her diagnosis?	☐	☐	
4. Does the youth know the dosage(s)?	☐	☐	
5. Is the youth aware of the potential side effects?	☐	☐	
6. Does the youth know the medication schedule?	☐	☐	
7. Does the youth self-administer the meds?	☐	☐	
8. Does the youth know the prescribing physician's name and contact information?	☐	☐	
9. Does the youth know how to make an appointment with the prescribing physician?	☐	☐	
10. Does the youth understand the danger of stopping the meds without consulting the prescribing physician?	☐	☐	
11. Does the youth have medical coverage?	☐	☐	
12. Does the youth know how to use the medical coverage?	☐	☐	
13. Does the youth know how and where to refill medical prescriptions?	☐	☐	
14. Does the youth have copies of his/her medical records and history?	☐	☐	
15. Does the youth have a trusted adult to talk with about medical issues?	☐	☐	
16. Does the youth have contact information for the designated consulting public health nurse (PHN)?	☐	☐	

Name of Youth _____ Case Number _____ ☐ DCFS ☐ Probation

Name of Preparer _____ Agency _____ Date Prepared _____

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SACHI A. HAMAI
Chief Executive Officer

June 5, 2019

To: Supervisor Janice Hahn, Chair
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Kathryn Barger

From: Sachi A. Hamai
Chief Executive Officer

REPORT BACK ON THE CENTRALIZED TRANSITIONAL-AGED YOUTH HUB (ITEM NO. 17, AGENDA OF JULY 24, 2018)

On July 24, 2018, the Board of Supervisors (Board), in response to the Chief Executive Office (CEO) July 6, 2018 report "Los Angeles County Centralized Transitional-Aged Youth (TAY) Hub: Supporting Successful Transition of Foster Youth to Adulthood," directed the CEO to report on recommendations to develop and launch a Centralized Transitional-Aged Youth Hub (Hub), and further report on the following:

1. Explore internal and external options to develop and launch the Hub, including collaboration with the Center for Strategic Partnerships (CSP) to support philanthropic engagement as appropriate, and identify any additional funding as necessary;
2. Coordinate with the Office of Child Protection (OCP) and all relevant County departments and partner agencies to implement a governance structure (including key internal and external stakeholders and advocates) to guide the implementation of the proposed multi-year strategy; and
3. Work with relevant County department leadership to develop Management Appraisal Performance Program (MAPP) goals that will ensure streamlining and effective service delivery to meet the needs of TAY and support the implementation and utilization of the Hub.

This memo provides updates on the CEO's efforts and progress to-date in the development and implementation of the Hub, beginning with the following background:

The July 6, 2018, TAY report detailed the work and recommendations from a CEO and OCP convened TAY Countywide Departmental Self-Sufficiency Committee. The Committee was comprised of twelve County departments, who identified internal and inter-departmental process opportunities to better inform and engage TAY and their support network regarding available TAY County resources.

The report's main recommendation was to align all the County's TAY resources through a centralized online system, currently called the Hub. The Hub would allow TAY support networks to more effectively engage and connect TAY to available County resources, including County line operations staff, caregivers, key external stakeholders, and TAY themselves. The system also would allow resources to be allocated based on TAY placement data trends and to identify resource gaps.

Developing and Launching the Hub

The CEO's Service Integration Branch (SIB), Chief Information Office (CIO), and CSP engaged in a series of discussions, including an October 2018 meeting with two key philanthropic organizations who currently support TAY efforts within Los Angeles County, and have determined the following viable options to develop and launch the Hub:

- A public-private sector collaboration partnership approach in developing and launching the Hub seems promising based on all discussions;
- Having philanthropy as a member of the Hub Governance Structure;
- Development Hub would align with the CIO's strategic County information platform;
- Leveraging existing entities who have online TAY information and referral systems to develop and launch the Hub, which would both reduce and determine actual costs; and
- In addition to philanthropic support, access available County funding to support the Hub, such as the Quality Productivity Commission's Productivity Investment Funds.

Development of a Governance Structure for Hub Development

The CEO, in conjunction with the OCP and the Department of Children and Family Services (DCFS), instituted a departmental and stakeholder-approved Governance Structure that is codified in Attachment I, "Centralized Transitional-Aged Youth (TAY) Hub Project Charter (Charter)." The Charter was created to ensure that all participants in the Governance Structure maintain a clear focus on the Hub's development and launch planning, by defining the Hub Project's Purpose, Overview, and Scope (what needs to be accomplished and how).

The Scope identifies the Governance Structure, which has three main components (Executive Sponsors, Steering Committee, and Core Teams), as summarized in Attachment II, "Summary of the Governance Structure." Included in the summary are the key responsibilities and current membership of each component and frequency of when each is convened. To-date, all the Governance Structure components are in place and fully functioning, with the Steering Committee comprised of key external stakeholders (like philanthropic and child advocate groups) and foster youth representation, along with County departments.

Highlights of the work accomplished thus far through the established Governance Structure, are shown in Attachment III, "TAY Hub Development Target Timeline," including:

- Completion of the Hub end user requirements/storyboards in April 2019; and
- Release of a Request For Information (RFI) on May 13, 2019, to determine existing TAY providers who have online systems that can meet the County end user requirements/storyboards. (Note: The RFI results will assist in determining the costs to build the Hub and next steps for a formal solicitation.)

MAPP Goals to Support Hub Development

Department Steering Committee members meet in early September to begin developing 2018-2019 goals for those Committee representatives in MAPP classifications. The following goal was finalized at the November 2018 Steering Committee:

- *Designated department representatives will participate in the Hub Governance Structure (Executive Sponsors, HUB Steering Committee, and/or Core Team) by: 1) Attending all scheduled meetings; 2) Developing, by December 2018, project plans for the rating period; and 3) Successfully completing all designated plan steps by the end of the rating period, June 30, 2019.*

The goal is currently part of the 2018-2019 MAPP plans of the two key lead departments integral to the overall Hub Governance Structure: CEO-SIB and DCFS. The current Hub MAPP goals will be revisited during the June 2019 Steering Committee meeting, and new goals will be drafted for the 2019-2020 MAPP year.

In conclusion, a progress report will be provided in December 2019, where significant progress on the Hub implementation phase is expected to be fully reported.

If you have any questions or need additional information, please contact me directly, or your staff may contact Fesia Davenport at (213) 974-1186, or by email at fdavenport@ceo.lacounty.gov.

SAH:FAD
HK:km

Attachments

c: Executive Office, Board of Supervisors
County Counsel
Children and Family Services
Consumer and Business Affairs
Health Agency
Health Services
LA County Library
Mental Health
Office of Child Protection
Parks and Recreation
Probation
Public Health
Public Social Services
Workforce Development, Aging and Community Services
Los Angeles County Office of Education
Los Angeles Homeless Services Authority

CHIEF EXECUTIVE OFFICE

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Centralized Transitional-Aged Youth (TAY) Hub

Project Charter

December 2018

Charter Prepared By:
Chief Executive Office - Service Integration Branch

Charter Approved: December 2018

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PROJECT CHARTER PURPOSE

The Centralized Transitional-Aged Youth (TAY) Hub initiative is centered on providing a solution to improve TAY self-sufficiency outcomes in the County of Los Angeles, using a centralized, online system. This proposed system is envisioned as an enhancement to County work that is currently being performed to help TAY on their pathway to self-sufficiency.

The purpose of this project charter is to guide the development and/or configuration of this online system by:

- Providing a comprehensive understanding of the purpose of the Centralized TAY Hub and justification for its implementation.
- Establishing a clear project scope that includes objectives, high-level requirements, key deliverables, milestones, boundaries, and risks.
- Identifying the organizational structure required for the Centralized TAY Hub's successful implementation and ongoing operations.

Executive Sponsors:

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Participating County Departments and Agencies include:

Chief Executive Office
Chief Information Office
Department of Children and Family Services
Department of Consumer and Business Affairs
Department of Health Services
Department of Mental Health
Department of Parks and Recreation
Department of Public Social Services
Department of Public Health
Los Angeles County Commission for Children and Families
Los Angeles County Library
Los Angeles County Office of Education
Los Angeles County Probation Department
Office of Child Protection
Workforce Development, Aging and Community Services

Participating Community Agencies include:

Alliance for Children's Rights
California Youth Connection
Child Trends / Hilton Foundation
Children's Law Center
Conrad Hilton Foundation
J. Burton Advocates for Youth
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PROJECT OVERVIEW

Background

On August 22, 2017, the Board of Supervisors (Board) adopted a motion that recognized Transitional-Aged Youth (TAY) who age out of the foster care system from the Department of Children and Family Services (DCFS) and Probation Department (Probation), as the most vulnerable within Los Angeles County's disconnected youth population, as evidenced by poor young adult outcomes.

As such, the Board motion ordered the Chief Executive Office (CEO), in conjunction with the Office of Child Protection (OCP), to coordinate with all relevant County departments to coalesce existing efforts as the basis for a cohesive multi-year strategy that will support the self-sufficiency goals of transitional-aged foster youth at the earliest stage possible.

Specifically, this multi-year strategy is comprised of the Preparation, Development and Implementation phases and includes: 1) the identification of all existing programs, services, funding streams and working groups that serve TAY and AB 12 youth (including any shortfalls or gaps in service or ineffective programs, as well as any successful initiatives for consideration of full implementation); 2) involvement and input of senior level staff within each relevant County department (and across department divisions), along with key internal and external stakeholders, philanthropic organizations and advocates; 3) identification of lead departments for each goal and objective, to serve as the basis for ongoing Management Appraisal and Performance Goals (MAPP) for department directors until the plan is implemented and fully operational; 4) assisting with efforts to streamline business processes and policies across departments to improve the delivery of coordinated/integrated services and supports to TAY; and 5) producing data indicators (including base data and anticipated outcomes) and strategies for evaluation of implementation efforts.

Purpose

The above-mentioned multi-year strategy is expected to produce a Centralized TAY Hub to be used by TAY and their support network, including County staff, caregivers, and others who support TAY. The Centralized TAY Hub concept is a proposed web-based model that facilitates access to information, from multiple sources, intended to assist and guide TAY in meeting their self-sufficiency goals.

In its final form, the Centralized TAY Hub should reflect a combined TAY-focused support network embedded within County departments and on-the-ground community organizations to:

1. Centralize countywide TAY resources and supports in one place, online;
2. Provide continuous online accessibility to TAY and their support network; and
3. Integrate specific strategies that engage TAY through the Hub (such as live, peer-to-peer interaction with trained and hired foster youth, including former foster youth).

High-level Requirements

This multi-year project plan requires the following two key preliminary steps before the project plan can begin.

1. Creation of a Governance Structure (with a preference for a public-private sector partnership) that can effectively build the proposed concept; and
2. Exploration of non-County funding opportunities to pay for the planning, development, implementation, and maintenance of the proposed concept.

Overall Project Risks

1. Integration Risks
    a. Complexity of County programs and service coordination will affect the structure and purpose of TAY Hub system components; and
    b. Complexity of TAY Hub system components will require interagency cooperation and coordination of services and supports.

2. Resource Risks
    a. Uncertainties with the funding sources selected for maintaining the ongoing operations of the proposed Centralized TAY Hub system after initial implementation; and
    b. The amount of funding available for the project may include sources with funding limitations.

3. Potential Conflicts of Interest
    a. Unauthorized use or disclosure of confidential ("Insider") information; and
    b. Stakeholder has a personal interest, obligation, loyalty or affiliation that may influence the:
        i. Responsibilities of their position in the Governance Structure
        ii. Outcome of the procurement of solution option(s)

PROJECT SCOPE

This project scope describes the TAY Hub Governance Structure and key system components needed to guide its development and implementation (Phase I), and subsequent, ongoing operations (Phase II and III – Under development).

Key Deliverables

1. Create a governance structure for the preparation, development and implementation of the multi-year strategy and ongoing operations.
2. Secure Funding/Funding Sources.
3. Develop the Centralized TAY Hub system.
    a. Taxonomy of services
    b. Detailed system technical and functional requirements for the Centralized TAY Hub system
4. Develop data indicators/metrics for data studies and evaluation of TAY Hub system.
5. Draft MAPP goals for designated Executive Sponsors and Steering Committee members to ensure implementation and utilization of the Centralized TAY Hub system.
6. Assist with efforts to streamline processes/policies across departments and improve the delivery of coordinated/integrated services and supports to TAY.
7. Develop Knowledge Transfer Plan.

Phase I

Governance Structure

The development of the Governance Structure requires the following components.

1. Establishment of a Steering Committee (a public-private sector partnership), roles and responsibilities and guidelines (See Attachment III: *Transitional-Aged Youth Hub (TAY Hub) Steering Committee Guidelines*) to provide oversight, strategic direction, and support to enhancement requests and technical issues.
    a. Executive Sponsors
    b. Steering Committee members
    c. Core Teams
        i. Technical Advisors
        ii. Business Process Leaders
        iii. Subject Matter Experts

2. Exploration of non-County options (private sector, philanthropic, etc.,) to fund planning, development, and implementation of the TAY Hub.

3. Development of Management Appraisal Performance Program goals to support the Preparation, Development, and Implementation strategies of the Centralized TAY Hub.

Key System Requirements

The development of the key system (functional / end user) requirements requires the following:

1. Solicitation of stakeholder feedback from the following user groups, and refinement of the following (previously obtained) high-level TAY Hub "End User Requirements."
    a. TAY
    b. Line Workers
    c. Administrators
    d. Community Stakeholders
    e. Resource/Relative Caregivers

2. A case management module, designed according to the needs and specifications provided by County case workers, caregivers, and service providers, to improve management of their TAY cases.

3. A module to track outcomes resulting from the use of the referred resources (services, supports, and events).

4. A referral module that will:
    a. Assess the needs of each specific TAY user, based on their unique preferences and circumstances defined in their individual profile, which will help provide the means through which TAY can apply for resources
    b. Keep track of searches, referrals and related notifications, and their outcomes

5. An information repository module of external and internal resources (services, supports, and events) organized by specific service categories within a custom proprietary taxonomy.

6. A self-service learning management system, that will provide a platform to help TAY understand how specific resources will help them achieve self-sufficiency resources, contextualizing resources using teaching content (e.g., "how to's" and "learning tools" content).

7. A module that will allow sharing of information between County departments and/or between various other entities, as permitted.

8. An interface to facilitate the contribution of data related to resources from the Internal (County) and external (Community Based Organizations, private) stakeholders for the content of the resource repository.

9. An interface to internal and external systems to exchange referral information.

10. System will meet all privacy and security requirements mandated by County, State, and federal regulations.

Procurement

The procurement and development of the solution option(s) requires the following:

1. Procure solution option(s) as developed.
    a. Submit final TAY Hub requirements to CIO
    b. CIO review/approve requirements with solution option(s) that integrate with County's Information Hub
2. Identify funding for solution option(s).
3. Identify / procure solution option(s) and services to implement the TAY Hub.
    a. Develop TAY Hub
    b. Work with vendor, CIO, and the Governance Structure (Executive Sponsors, Steering Committee, and Core Teams) to develop the identified solution option(s)

Implementation

Following the procurement process and TAY Hub development, the Governance Structure will be operationalized using the following documents to ensure the TAY Hub's successful implementation and ongoing operations (Phase II):

1. TAY Hub Governance Structure Org Chart (Exhibit I);
2. TAY Hub Governance Structure Responsibilities (Exhibit II);
3. TAY Steering Committee Guidelines (Exhibit III); and
4. Summary Milestone Schedule / Project Plan (Exhibit IV).

Project Boundaries

This project takes into consideration the identification of detailed system requirements and the acquisition of the proposed system; the development of the taxonomy of services to use; the creation of an organizational structure needed to oversee the implementation and ongoing operations of the TAY Hub; and review of business processes and policies across departments to explore how improvements could be made to the delivery of coordinated/integrated services and supports to TAY. Therefore, it is important to note the following items:

1. Departments will explore possibilities for modifying their service systems to interface with the Centralized TAY Hub.
2. Process and Workflow Updates – Departments will engage in coordinating process improvement and workflow modification efforts based on the agreed upon configuration of the Centralized TAY Hub.
3. Development of any content required for the system except for the Taxonomy of Services.
4. Acquisition of resources required for the organizational structures identified for the implementation and ongoing operations of the Centralized TAY Hub.

Summary Milestones Schedule /Project Plan

See Exhibit IV

Project Constraints / Dependencies

Executive Sponsors and Project Managers will work with County Counsel to address any legal constraints and/or privacy issues and ensure that the exchange of information is consistent with State and Federal Law.

Phases II and III

Currently under development

Exhibit I

TAY Hub Governance Structure Org Chart

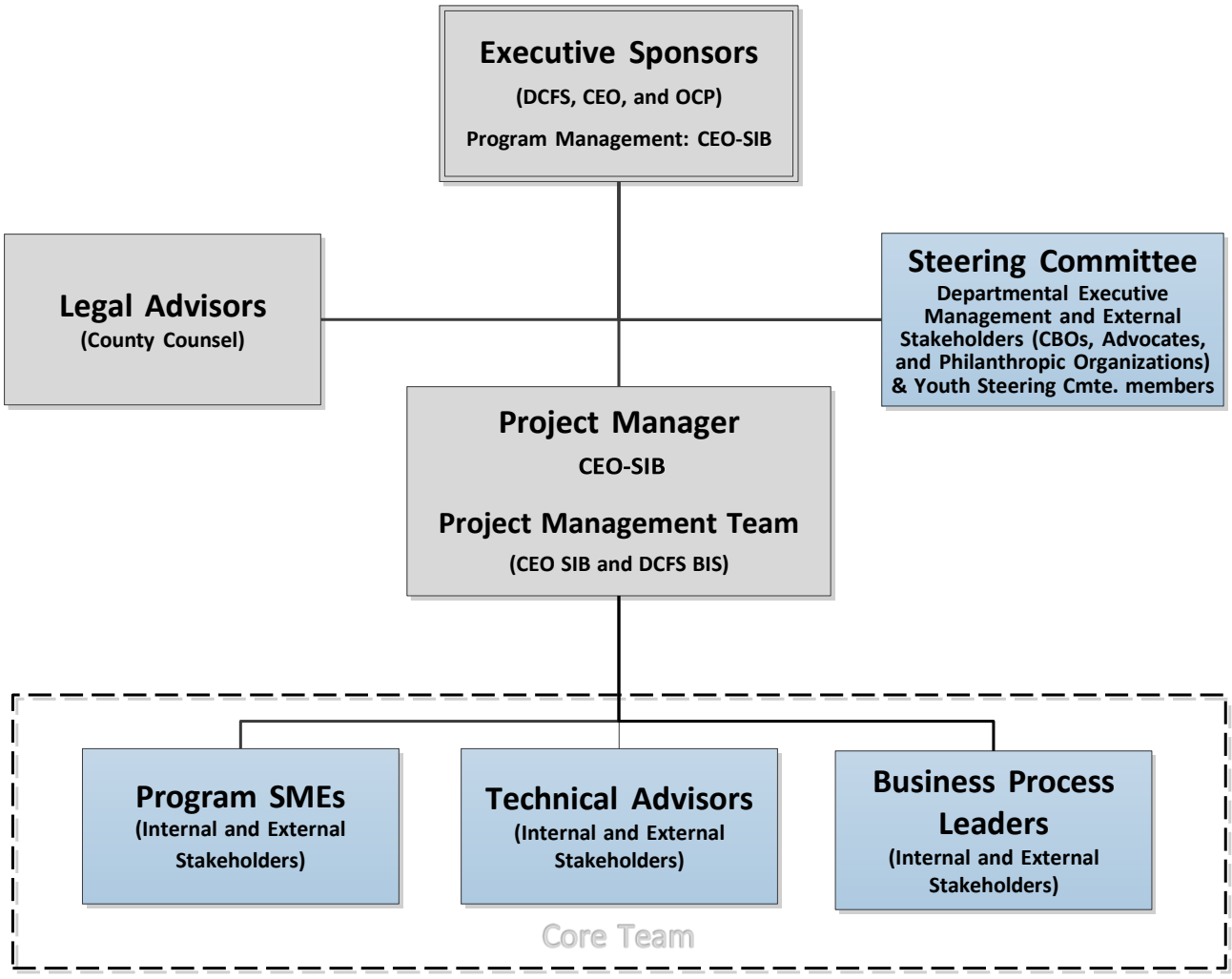

Exhibit II

TAY Hub Governance Structure Responsibilities

Governance Structure Group	Responsibilities
Executive Sponsors (CEO, DCFS and OCP)	- Sets project strategy - Reviews milestone adherence - Reviews and provides guidance on risk mitigation - Is the final point of resolution for issue escalation, resource conflicts, functionality concerns, and policy and workflow concerns - Provides guidance on other projects that may have an impact on the Centralized TAY Hub Project - Provides approval for all required Board submissions - Chairs Steering Committee Meetings
Steering Committee (County Depts. Reps. and external stakeholders)	- Provides guidance team for the Centralized TAY Hub Project to address and resolve: o Resource conflicts o Escalated issues o Functionality concerns o Policy and workflow concerns - Attends Steering Committee Meetings on a regular basis - Designates representatives to the Core Group, as needed - Steering Committee members can also serve on the Core Team, as requested - Comments received from County departments: o Develops plan for marketing strategy o Develops the Information Sharing Policy o Include Foundations that fund TAY efforts (e.g., Pritzker Foundation, Hilton Foundation, etc.) Suggested meeting protocols/decision-making/membership: ▪ Unanimous-majority ▪ Facilitated discussions ▪ Risk Management – Security, privacy ▪ Note Taking – Action Items reported ▪ Follow-up ▪ Include department liaisons

Governance Structure Group	Responsibilities

Legal Advisors (County Counsel)	- Provides guidance and legal opinion on all matters requiring legal counsel, including but not limited to:
	  o HIPAA and Privacy Guidance
	  o Data Sharing
	  o Procurement
	- Attends Steering Committee meetings, as required

Project Manager (CEO-SIB)	- Provides oversight for the technical/development aspects of the project - Leads the team through the technical/development phases of the project - Coordinates the development of a detailed project plan - Owns, updates, and manages the project plan, once defined and agreed upon by the Core Team and Steering Committee - Oversees issue management process - Oversees risk management process - Oversees communications management process - Facilitates conflict resolution and healthy team dynamics - Provides guidance on and tracks adherence to quality management process - Provides regular reporting to the Executive Sponsor and Steering Committee
Project Management Team (CEO-SIB and DCFS)	- Provides oversight and coordination between and among departments and other entities for the successful completion of the deliverables for the TAY Hub - Prepares, documents, and publishes meeting Agendas and Minutes - Develops a detailed project plan

CORE TEAM	
Program Subject Matter Experts (SMEs) (Internal and external stakeholders)	- Attends Core Team Meetings - Represent internal and external stakeholders who will consult their respective departmental Business Leaders by providing input on the workflow, taxonomy of services and detail functional requirements for the Centralized TAY Hub system - Comments received from County departments: SMEs could potentially include: o Group home/Short-Term Residential Therapeutic Program and Probation/DCFS and Public Health Nurses; foster parents (resource families) and engage TAY over time. o Stakeholders, such as: LA LGBT Center; Department of Mental Health (DMH) TAY Drop-in Centers/Shelter; Domestic Violence Providers, Community Colleges; Cal State Colleges; UC System Colleges; Private Universities; Faith-based providers; DMH; Department of Public and Social Services; Foundations that fund TAY; Regional Centers, Adolescent Family Life Program's (Cal-learn providers), etc.
Technical Advisors (Internal and external stakeholders)	- Attends Core Team Meetings on behalf of Chief Information Office, Internal Services Department, and Information Technology Divisions of participating representatives from internal and external stakeholders - Provides guidance and recommendations regarding technology architecture standards and ensures said standards are used in the design and/or customization of the Centralized TAY Hub system - Comments received from County departments: This group should include representatives of any system that will interface with the Hub

Business Process Leaders (Internal and external stakeholders)	- Attends Core Team Meetings on behalf their respective participating representatives from internal and external stakeholders - Defines and documents business requirements for their department/organization - Reviews, updates, and approves functional requirements for their department/ organization - Is responsible for process and workflow assessment and design within department/ organization - Comments received from County departments: Group could potentially include: o The Chamber of Commerce; Legal CBOs; DPSS - GAIN (Greater Avenues of Independent Living – to help access jobs and job training); Parks and Recreation (including Parks After Dark); Youth Councils/Teen Clubs, consider adding Google, Microsoft, etc.

Exhibit III

TRANSITIONAL-AGED YOUTH HUB (TAY HUB)
STEERING COMMITTEE AND CORE TEAM GUIDELINES

UNDERSTANDING

Steering Committee

The purpose of the TAY Hub Steering Committee (Steering Committee) is to guide the implementation and maintenance of the proposed online TAY Hub that will:

1. Consolidate existing countywide resources on a single platform;
2. Provide continuous online access; and
3. Engage TAY through online interaction and live peer-to-peer foster youth involvement to link youth to the right services and programs.

The Committee's focus is to:

1. Explore internal and external options to develop and launch the Hub;
2. Coordinate with the Department of Children and Family Services, the Office of Child Protection and all relevant County departments and partner agencies to implement a governance structure that will guide implementation; and
3. Work with County department leadership to develop MAPP goals to ensure streamlined and effective service delivery.

The Steering Committee is responsible for co-developing strategies for implementing these efforts.

Core Teams

The purpose of the TAY Hub Core Teams (Core Teams) is to perform ad hoc duties, as needed, to operationalize and maintain TAY Hub implementation strategies, co-developed and assigned by the Steering Committee, through subject matter expertise, technical assistance and business processes definition and alignment.

ROLES AND RESPONSIBILITIES OF ASSIGNED STEERING COMMITTEE AND CORE TEAM MEMBERS

In addition to the roles and responsibilities outlined below, please refer to the *TAY Hub Governance Responsibilities* handout.

1. Attendance
    a. **Steering Committee and (Core Team) members are expected** to attend at least *nine (TBD)* monthly meetings per year, either in person or by conference call;
    b. **If a member cannot attend a meeting**, a representative from that organization needs to attend on his/her behalf. Representatives will be responsible for communicating any updates, pertinent information discussed, and decisions taken at the meeting that was missed;
    c. **In the event that a member leaves the Steering Committee or Core Team**, it will be that member's responsibility to onboard his/her replacement. This is to preserve the continuity of the committee's efforts; and
    d. **Members (or their representatives) that fail to adhere to 1a and 1b** above, will result in forfeiture of the organization's seat on the Steering Committee or Core Team.

2. Participation/Expectations
    a. **The purpose of the Steering Committee** is to inform and guide the Executive Sponsor's (CEO, DCFS and OCP) thinking/actions toward implementation of the TAY Hub. **The purpose of the Core Teams** is to support these efforts through the performance of assigned ad hoc duties.
    b. **Members are expected** to:
        i. **Be empowered by their organizations** to speak/make decisions on their behalf;
        ii. **Maintain the confidentiality** of the group;
        iii. **Complete any tasks/assignments** between meetings;
        iv. **Assign organizational representatives** to the Hub Core Groups;
        v. **Review and become familiar** with the agendas/materials that will be shared in advance of the meeting;
        vi. **Actively listen and participate** in discussions/debates or the formulation of recommendations to the Executive Sponsors;
        vii. **Treat each other with respect** and minimize interruptions and repetition of points previously made by other members;
        viii. **Proactively volunteer** to support planning and implementation activities of the body (e.g., organize focus groups, leverage organizational resources as needed, assign organizational representatives to Hub Core Groups, etc.).

MEETING LOGISTICS

1. Chairing/Facilitation
    a. **Meetings will be chaired** by at least one member of the Executive Sponsor Team (Executive Sponsors, CEO, DCFS or OCP); and
    b. **Supported/facilitated** by members of the CEO's Service Integration Branch.

2. Frequency/Start and End time

   Meetings shall:

   a. Be held monthly on the third Wednesday of every month from 1 PM – 3 PM (TBD at an agreed location). However, scheduling of these meeting may change as needed or as determined by the Chair(s); Core Team Meeting Attendance/Schedule: TBD
   b. Begin within five minutes of the scheduled start time and end on time; and
   c. Contain a 10-minute break if they are over two hours in duration.

3. Agendas

   a. Meeting agendas will be sent prior to each scheduled monthly meeting. Agendas are subject to change; however, the basic structure of the meeting will be as follows:

      i. Review of Minutes/Decision Points
      ii. Updates from Core Groups/Working Groups
      iii. Unfinished business
      iv. New business
      v. Items for next meeting

   b. Meeting notes/decision points will be distributed by the CEO after every meeting;
   c. Out of scope items will be parked until a future meeting of the body as deemed by the Chair(s); and
   d. Members will be provided the opportunity to shape/add items to the agenda for the following meeting.

4. Quorum

   a. In order for business to be conducted, a minimum number of Steering Committee and Core Team member organizations must be present; and
   b. The minimum number of member organizations needed to conduct business shall be one-half plus one.

5. Voting/Recommendations

   a. Decisions of the body will be obtained via consensus after an item is given ample time to be discussed/debated;
   b. Organizations can only have one official representative vote at meetings;
   c. The Chair(s) shall determine if the time allotted for discussion/debate has been sufficient;
   d. If consensus cannot be achieved after a reasonable amount of time for discussion and debate, the Executive Sponsor Team will make the decision. Their decision is binding; and
   e. Steering Committee and Core Team recommendations are made in the spirit of informing and guiding the Executive Sponsor's thinking and actions. Ultimately, however, the Executive Sponsors will have the final say as to whether they accept or reject any of the recommendations proposed.

Exhibit IV – SUMMARY MILESTONE SCHEDLULE /PROJECT PLAN

Updated Date of Plan: March 14, 2019
Key Members for Lead Duties: Project Managers (SIB), Executive Sponsors (ES), Steering Committee (SC) and Core Teams (CT)

ACTION ITEM	LEAD(S)	TARGET DATE	STATUS
Directive #1: Explore internal and external options to develop and launch a Centralized Transitional-Aged Youth (TAY) Hub, including collaboration with the Center for Strategic Partnerships (CSP) to support philanthropic engagement as appropriate and identify any additional funding necessary.			
Objective 1.1: Determine internal and external options.		**4/30/19**	
1.1.1: Meet with CEO Chief Information Office to discuss options for the Hub	SIB	8/30/18	Completed
1.1.2: Finalize internal and external options for the TAY Hub	SIB	9/30/18	Completed
1.1.3: Develop a timeline to realize options: end user personas as a first step	SIB	10/1/18	Completed
1.1.4: Schedule and host focus groups with five end users (TAY, line operations, administrators, caregivers and stakeholders)	SIB/SC	12/19/18	Completed. During the month of November 2018, convened nearly 200 Youth, Children Social Workers, Resource Parents, Community Stakeholders and Program Administrators in a series of focus group sessions. Was unable to coordinate a focus group session with relative caregivers.
1.1.5: Analysis of focus group input	SIB	12/18/18	Completed
1.1.6: Steering Committee to review end user personas	SC	12/31/18	Completed. End user requirements and SIB Information Technology / Infrastructure Development's (IT/ID) recommended priority levels were presented at the 12/19/18 SC meeting. SC agreed to revise document to reflect focus group and SC input.
1.1.7: Executive Sponsors to approve end user personas	ES	1/30/19	Completed 2/19
1.1.8: Approved end user personas to be sent to CEO Chief Information Office	SIB	3/15/19	Completed
1.1.9: Finalization of personas by CIO and determination of next steps to procure vendor	SIB	4/15/19	On 02/13/19, SIB submitted text storyboards (personas) to CIO, who requested final input from SC and validation by Core

ACTION ITEM	LEAD(S)	TARGET DATE	STATUS
			Teams. SIB agreed to present at the 02/20/19 SC meeting and follow-up Core Team meeting (TBD).
1.1.10: Meeting with CIO/Executive Sponsor to determine procurement strategies (second step)	SIB/ES	4/15/19	Completed
1.1.11: Finalization of procurement project plan (to be added as next steps for this objective) including target date for provider to be brought onboard	SIB/ES	TBD	
Objective 1.2: Philanthropic engagement and other funding.		**3/31/19**	
1.2.1: Meet with CSP to discuss philanthropic engagement	SIB	9/30/18	Completed
1.2.2: Meet with DCFS (Cynthia McCoy-Miller) re: funding	SIB/DCFS	9/30/18	Completed
1.2.3: Initial meeting with key philanthropic organizations	CSP	10/31/18	Completed
1.2.4: Build philanthropic engagement into timeline	SIB	10/1/18	Completed
1.2.5: Philanthropic representation at the Steering Committee	SIB	11/19/18	Completed
1.2.6: Develop philanthropic/funders engagement event	SIB with CSP	TBD	
1.2.7: Host philanthropic engagement event	CSP/SIB	TBD	
1.2.8: Finalize next steps re: funding and strategies with CIO and Executive Sponsors (add steps to this objective)	CSP/SIB/ES	TBD	
Directive #2: Coordinate with the Office of Child Protection (OCP) and all relevant County departments and partner agencies to implement a governance structure (including key and external stakeholders and advocates) to guide the implementation of the proposed multi-year strategy.			
Objective 2.1: Implement a governance structure.		**10/01/18**	
2.1.1: Completion of draft governance structure and timeline for implementation (through July 2019)	SIB	9/1/18	Completed. TAY Hub Implementation timeline was presented for ES/SC review at the 10/16/18 SC meeting.
2.1.2: Input from OCP and CIO on governance structure	SIB	9/30/18	Completed. On 09/17/18, met with OCP to discuss follow-up to CIO Proposed Framework.
2.1.3: Meeting with DCFS on governance structure	SIB/DCFS	9/30/18	Completed
2.1.4: Briefing departments regarding the governance structure (Executive Sponsor, Steering Committee and Core Teams) and MAPP goals	SIB/SC	9/30/18	Completed. Convened Departments on 10/02/18. Reviewed July 24, 2018 motion and provided overview of CIO's TAY Hub Solution Process, Governance Structure roles and

ACTION ITEM	LEAD(S)	TARGET DATE	STATUS
			responsibilities, MAPP goals, etc. Group work produced Governance Structure feedback and potential SC representations.
2.1.5: Convening of proposed Steering Committee and proposed timeline for implementation	SIB/SC	10/31/18	Completed. Convened the first TAY Hub SC meeting on 10/16/2018. Presented draft timeline for SC review.
2.1.6: Vetting of governance structure with Steering Committee (schedule and timeline)		11/30/18	Completed
2.1.7: Finalization of the Executive Sponsors designations	SIB/ES	12/19/18	Completed. Received email on 12/18/18, announcing final ES designations, increasing the number from 3 to 6 and giving majority decision-making authority to DCFS. Project charted updated to reflect changes.
2.1.8: Finalization of the formal governance structure by Steering Committee and Executive Sponsor groups	SC/ES	12/31/18	Completed. Governance structure was initially reviewed by the ES and SC members on 10/16/19 and presented again as part of the TAY Hub SC Project Charter at the 11/21/18 SC meeting.
2.1.9: Finalization of Core Team members	ES/SC	12/31/18	Completed. Eventbrite invitation, sent 01/03/19, was used as mechanism for TAY ES/SC to designate Core Team members. Deadline for designation was set at 01/10/19. SIB received 37 designations.
2.1.10: Orientation of Core Team members	SIB	1/31/2019	Completed. Conducted orientation for approximately

Exhibit IV – SUMMARY MILESTONE SCHEDLULE /PROJECT PLAN

ACTION ITEM	LEAD(S)	TARGET DATE	STATUS
			35 Core Team members on 01/29/19.
Objective 2.2: Guiding the implementation of the multi-year strategy.		**6/2019**	
2.2.1: Establish monthly meeting schedule 2019 for the Governance Structure	SIB/SC/ES	12/19/18	Completed
2.2.2: Establish Core Team activation schedule and protocol based on Objective 3.2	SIB/SC	2/27/19	Completed
2.2.3: Establish centralized share point site for all Governance Structure members	SIB	1/31/19	Missed target. Initiated request with CEO-ITS on 01/02/19. Sent follow-up request on 01/10/19. Received response on 01/14/19 advising that SIB's ITID have already created TAY SharePoint site. Per SIB's IT/ID, the site has never been used. However, folders can be relabeled for current needs.
2.2.4: Provide Board update report on Hub progress	SIB/ES	5/30/19	
2.2.5: Develop a project plan for oversight of the procured provider (See 1.1.11) – project plan steps to be added to this Objective	SIB/SC/ES	For FY 19-20 plans	
Directive #3: Work with relevant County department leadership to develop Management Appraisal Performance Program (MAPP) goals that will ensure streamlined and effective service delivery to meet the needs of TAY, and support the implementation and utilization of the Centralized TAY Hub.			
Objective 3.1: Develop 2018-2019 MAPP goals to support Hub.		**12/31/18**	
3.1.1: MAPP goals drafted for Steering Committee vetting	SIB	9/15/18	Completed
3.1.2: Draft goals presented to Steering Committee	SIB	10/31/18	Completed
3.1.3: Feedback on draft MAPP goals from Steering Committee	SIB	11/19/18	Completed
3.1.4: Finalization of MAPP goal and project plan details	ES	12/19/18	Completed
Objective 3.2: Streamlined and effective service delivery for TAY.		**9/30/19**	
3.2.1: Steering Committee will identify specific areas for streamlining and more effective delivery of TAY services	SC/SIB	5/30/19	
3.2.2: Engagement of Core Teams to address specific areas	SIB/CT	TBD	
3.2.3: Recommendations back from Core Teams	SIB/SC	TBD	
3.2.4: Recommendations from Steering Committee	SIB/SC	TBD	
3.2.5: Final decisions made by Executive Sponsors	ES	TBD	
Objective 3.3: Support implementation and utilization of the Hub.		**8/30/19**	
3.3.1: Steering Committee to discuss media/PR strategies at June 2019 meetings, including funding	SC/SIB	6/30/19	

Exhibit IV – SUMMARY MILESTONE SCHEDLULE /PROJECT PLAN

ACTION ITEM	LEAD(S)	TARGET DATE	STATUS
3.3.2: Detailed project plans finalized by Executive Sponsor	ES/SIB	7/30/19	
3.3.3: Project plans next steps will be added to Objective 3.3.	SIB	7/30/19	
Objective 3.4: Draft 2019-2020 MAPP goals to support the Hub.		**6/30/19**	
3.4.1: Steering Committee to draft next steps needed for FY 2019-2020	Depts.	6/30/19	
3.4.2: Executive Sponsor to finalize draft MAPP goals	Depts.	7/30/19	
3.4.3: CEO to vet MAPP goals with Board Offices	SIB	8/15/19	
3.4.4: MAPP goals presented as part of DH goals	CEO	TBD	

Attachment II

SUMMARY OF HUB GOVERNANCE STRUCTURE

ENTITY	KEY RESPONSIBILITES	PARTICIPATING MEMBERS	MEETING FREQUENCY
Executive Sponsors	*Decision-maker on all Hub matters and co-lead (with CEO) Steering Committee meetings*	*Sponsors (6)* • *CEO (1)* • *DCFS (4)* • *OCP (1)*	*Monthly and As-Needed*
Steering Committee **Implemented in September 2019**	*Reviews, provides input and recommendations to the Executive Sponsors on all Hub matters defined in Project Charter* *Designates representatives to serve on the Core Teams*	*County departments (15)* • *CEO Chief Information Office* • *Commission for Children & Families* • *LA County Library* • *Department of Consumer and Business Affairs* • *DCFS* • *Department of Public and Social Services (DPSS)* • *Health Services* • *Los Angeles County Office of Education (LACOE)* • *LA Homeless Service Authority* • *Mental Health* • *OCP* • *Parks and Recreation* • *Probation* • *Public Health* • *Workforce Development, Aging and Community Services (WDACS)* *External Stakeholders (12)* *Alliance for Children's Rights* *California Youth Connection* *City of Los Angeles (P3)* *Children's Law Center* *Conrad Hilton Foundation* *Foster Youth representative* *John Burton Foundation* *Los Angeles Compact* *Opportunity Youth Collaborative* *Pritzker Foundation* *Public Counsel*	*Monthly as of October 2018*
Core Teams **Implemented in January 2019**	*Provides Steering Committee input, feedback, and recommendations to Hub issues referred by the Committee, in three Core Team expertise areas:* • *Business Process (Technology)* • *Subject Matter Experts (TAY engagement)* • *Technical Process (Programs)*	*Business Process Team (8)* • *LA County Library (1)* • *DCFS (3)* • *DPSS (3)* • *Probation (1)* *Subject Matter Expert Team (22)* • *Association of Community Human Service Agency (1)* • *LA County Library (1)* • *Children's Law Center (3)* • *California Youth Connections (1)* • *DCFS (7)* • *DPSS (1)* • *LACOE (3)* • *Parks and Recreation (1)* • *Probation (1)* • *Public Health (1)* • *Public Counsel (1)* • *WDACS (1)*	*Convenes As-Needed*

SUMMARY OF HUB GOVERNANCE STRUCTURE

		<u>Technical Process Team (8)</u> • *DCFS (1)* • *DMH (1)* • *DPSS (5)* • *Parks and Recreation (1)*	

ATTACHMENT III

TAY Hub Development Target Timeline

PHASE I

JUL 24 2018

- **Transitional-Aged Youth (TAY Motion)**

OCT 2 2018

- **Convened TAY Hub and Governance Structure Meeting with County Departments** to:
  - Refine governance structure
  - Identify potential Steering Committee/Core Team members
  - Discuss /develop MAPP goals

OCT 16 2018

- **Launched TAY Hub Steering Committee Inaugural Meeting** to:
  - Introduce County and Non-County representatives
  - Define roles and responsibilities
  - Review Core Team meeting structure

NOV 2018

- **Conducted Focus Group Meetings** to:
  - Finalize TAY Hub Functional Requirements
  - Identify potential Core Team members

NOV 30 2018

- **Established Governance:**
  - Governance Structure
  - TAY Hub Requirements
  - Projected Timeline

DEC 19 2018

- **Steering Committee approval** of **TAY Hub Project Charter**, and
- Review of draft TAY End User Personas (Storyboard)

JAN 29 2019

- **Conducted TAY Hub Core Team Orientation** to provide overview of:
  - TAY Hub Governance, Solution and Storyboard Process, and Next Steps

FEB 6-7 2019

- Facilitated **Storyboard sessions** to obtain high-level input needed to develop the Storyboards

FEB 20 2019

- **Final Steering Committee review** of all TAY Storyboards

MAR 6 & 14 2019

- Convened:
  - **TAY Hub Core Teams** to validate the Storyboards
  - **Youth Committee** to validate the TAY Storyboard

MAR 20 2019

- **TAY Hub Steering Committee Meeting**
- Discuss **procurement process**
- Begin process of **identifying areas for streamlining** / more efficient service delivery

MAR 2019

- **Final Storyboards** submitted to CIO
- **Establish centralized SharePoint Site** for the Governance Body

TAY Hub Development Target Timeline

PHASE II - Development (DRAFT)

MAR-APR 2019

- **CIO:**
  - Review requirements contained in the Storyboards
  - Develop timeline for the Solutions Procurement Process

MAY 2019

- **Conduct technical scan** of potential vendors
- **Initiate RFI** process
- Steering Committee, Contracts and County Counsel **review and approval of draft RFI**
- **Finalize RFI**

MAY 13 2019

- **RFI** posted for distribution to potential vendors

JUN-JUL 2019

- Schedule **vendor demonstrations**
- Generate **estimated costs** of potential TAY Hub Solution(s)
- Begin Steering Committee **alignment opportunity presentations**

JUL-ONGOING

- **Convene Core Teams** to begin drill down, aligning and streamllining of identified opportunities, TAY Storyboard processes and Hub technical functions

JUL-ONGOING

- **Steering Committee** to begin guiding/reviewing Core Team's recommendations
- **Approved recommendations** to be submitted to the Executive Sponsors for consideration and action

PHASE III – Implementation (DRAFT)

AUG-DEC 2019

- Develop **philanthropic engagement** timeline
- Convene key philanthropic organizations
- Finalize funding strategies (includes County funds)

TBD

- Initiate **Solutions Procurement "next steps"** (e.g., RFP, Sole Source, Delegated Authority, etc.)
- Select and procure **TAY Hub Solution(s)**

TBD

- **Convene vendor(s) and Core Teams** to review and finalize alignment opportunities, TAY Storyboard processes and Hub technical functions
- **Phased production of** TAY Hub modules

TBD

- **Marketing** strategy is developed
- **End User Focus Groups** Beta Test module
- **Marketing** strategy is also tested
- **Module/marketing strategy are modified** based on feedback received from Beta Test groups

TBD

- **End Users test** final module
- **End user training** developed and tested
- **Marketing** strategy is finalized

TBD

- **Module is** prepped for launch
- **Launch** first module/ monitor for QA
- **Repeat process** for subsequent modules

Note: *Steering Committee and Core Team functions are ongoing*

County of Los Angeles
CHIEF EXECUTIVE OFFICE
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SACHI A. HAMAI
Chief Executive Officer

August 18, 2020

To: Supervisor Kathryn Barger, Chair
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Janice Hahn

From: Sachi A. Hamai
Chief Executive Officer

REPORT BACK ON THE CENTRALIZED TRANSITIONAL-AGED YOUTH HUB (ITEM NO. 17, AGENDA OF JULY 24, 2018)

On July 24, 2018, the Board of Supervisors (Board), in response to the Chief Executive Office's (CEO) July 6, 2018 report *Los Angeles County Centralized Transitional-Aged Youth (TAY) Hub: Supporting Successful Transition of Foster Youth to Adulthood*, directed the CEO to report on recommendations to develop and launch a Centralized Transitional-Aged Youth Hub, and further report on the following:

1. Explore internal and external options to develop and launch the Hub, including collaboration with the Center for Strategic Partnerships (CSP) to support philanthropic engagement as appropriate, and identify any additional funding as necessary;
2. Coordinate with the Office of Child Protection (OCP) and all relevant County departments and partner agencies to implement a governance structure (including key internal and external stakeholders and advocates) to guide the implementation of the proposed multi-year strategy; and
3. Work with relevant County department leadership to develop Management Appraisal Performance Program (MAPP) goals that will ensure streamlining and effective service delivery to meet the needs of TAY and support the implementation and utilization of the Hub.

This memo serves as an update to the CEO's December 26, 2019 report. The activities and recommendations outlined in this update were in progress before the Coronavirus (COVID-19) pandemic, and prior to the severe negative impact that it had on the County's budget. The report chronicles progress made toward developing a *Los Angeles County Community Information Exchange* (LACCIE); drafting a new Request for Proposals (RFP) to enhance the County's Information and Referral (I&R) service system; and facilitating the development of the TAY Hub.

In the December 2020 report, the CEO highlighted several key TAY Hub accomplishments, including completion of a Request for Information process that resulted in a series of vendor demonstrations. Based on the capabilities observed, and the need to replace the current I&R contract that expires in December 2021, the CEO, Chief Information Office (CIO), OCP and the Department of Children and Family Services (DCFS) agreed that creation of the TAY Hub presented an opportunity for the County to more efficiently and cost effectively meet the I&R and service-linkage needs of departments by leveraging existing County technology and resources and initiating an RFP for a set of reimagined County I&R services. To achieve these goals, the new I&R RFP contains all of the requirements necessary to establish the TAY Hub, meet departments' needs, and connect to LACCIE – the County's behind-the-scene information and communication brokering system, currently under development.

Department Convenings to Confirm Needs

To confirm the I&R and service-linkage needs of the County, the CEO, CIO, OCP and KH Consulting Group convened nearly a dozen departments/offices in a series of three working sessions in January/February 2020. These sessions were designed to:

1. Build on and incorporate the TAY Hub functions and requirements;
2. Identify and prioritize enhancements to I&R services, including tracking and connecting clients to services and providers;
3. Identify/assess operational barriers/opportunities and solutions to address them;
4. Create a business plan to implement I&R improvements; and
5. Inform the solicitation process for establishing the County's new I&R services.

Departments agreed that a County-owned LACCIE system for making and tracking client-service referrals was not only desirable, but more efficient and cost-effective than departments building their own systems to achieve similar outcomes. By the end of this process, the goals of the convenings were achieved and departments were ready to begin drafting the I&R RFP.

TAY Hub and the I&R RFP

Based on the input received during the convenings and the TAY Hub development process, the CEO, CIO, and OCP began to draft the I&R RFP. The RFP details how the new I&R services/requirements will be combined with LACCIE to create a County-owned system that aims to have the following capabilities and features:

1. Comprehensive, up-to-date registries of County/non-County services and providers;
2. More robust/user-friendly methods for users to access information and resources whenever they are needed, (e.g., via telephone, text, Instant Messaging, online chats, self-service portals, etc.); and
3. A shared platform for initiating, tracking and communicating the outcomes of client-service referrals among County and non-County providers.

With these new technical capabilities, I&R vendors would more easily be able to develop and pilot the TAY Hub portal, and leverage LACCIE's resources to establish the necessary functions/features needed to support the self-sufficiency goals of TAY. Additionally, behind the scenes, LACCIE would serve to bridge the service-referral-communication gap that exists between TAY, caregivers, County staff, community service providers, and key stakeholders.

Once the TAY Hub pilot has been successfully rolled-out, it is anticipated that, additional portals addressing the needs of other special populations would be phased-in. Such portals will connect departmental call centers with similar I&R and service-linkage services via LACCIE. Given the budget situation stemming from the severe economic downturn caused by the unprecedented COVID-19 pandemic, details related to the development and implementation of the RFP will be provided at a later time, pending the CEO's determination that proceeding with the RFP would be feasible.

Steering Committee and Vetting of I&R-LACCIE

In June 2020, an I&R RFP Steering Committee (SC), chaired by the CEO and supported by the CIO and OCP, was convened. The SC is comprised of the following departments: DCFS, Health Services, Mental Health, Public Health, Public Social Services, and Workforce Development, Aging and Community Services. The SC was created to:

1. Direct the solicitation, implementation and deployment of new I&R services;
2. Allocate resources and budget to implement and deploy these services; and
3. Direct and facilitate new services implementation.

Additionally, four webinars were held with 240 community providers in June 2020 including County departments, TAY providers, and advocates. The goals of the webinars were to:

1. Provide an overview of I&R-LACCIE and the County's implementation plans;
2. Receive feedback from providers/departments on the strengths/areas of improvement of current I&R services; and
3. Obtain input as what could be most helpful to clients/communities to meet their needs via this platform.

Feedback received during the webinars and via a subsequent survey were overwhelmingly positive and supported the direction of the County.

Next Steps

The CEO will continue to work with CSP to engage philanthropy in this effort and with impacted departments to develop MAPP goals to streamline service delivery and implementation/use of the TAY Hub. Future reports will include updates relating to the vendor selection and contracting process.

If you have any questions or need additional information, please contact me directly, or your staff may contact Tiana Murillo, Assistant Chief Executive Officer, at (213) 974-1186, or by email at TMurillo@ceo.lacounty.gov.

SAH:TJM
EDT:CP:km

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Children and Family Services
Consumer and Business Affairs
Health Services
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Mental Health
Parks and Recreation
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Workforce Development, Aging and Community Services
Los Angeles County Office of Education
Los Angeles Homeless Services Authority
Office of Child Protection

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FESIA A. DAVENPORT
Chief Executive Officer

June 15, 2021

To: Supervisor Hilda L. Solis, Chair
Supervisor Holly J. Mitchell
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger

From: Fesia A. Davenport
Chief Executive Officer

REPORT BACK ON THE CENTRALIZED TRANSITIONAL-AGED YOUTH HUB (ITEM NO. 17, AGENDA OF JULY 24, 2018)

On July 24, 2018, the Board of Supervisors (Board), in response to the County of Los Angeles (County) Chief Executive Office's (CEO) July 6, 2018 report, *Los Angeles County Centralized Transitional-Aged Youth (TAY) Hub: Supporting Successful Transition of Foster Youth to Adulthood*, directed the CEO to report on recommendations to develop and launch a Centralized TAY Hub, and further report on the following:

1. Explore internal and external options to develop and launch the TAY Hub, including collaboration with the Center for Strategic Partnerships (CSP) to support philanthropic engagement, as appropriate, and identify any additional funding, as necessary;
2. Coordinate with the Office of Child Protection (OCP) and all relevant County departments and partner agencies to implement a governance structure (including key internal and external stakeholders and advocates) to guide the implementation of the proposed multi-year strategy; and
3. Work with relevant County department leadership to develop Management Appraisal Performance Program (MAPP) goals that will ensure streamlining and effective service delivery to meet the needs of the TAY Hub and support the implementation and utilization of the Hub.

This report serves as an update to the CEO's August 18, 2020 memo, in which the CEO reported that the development of the TAY Hub was incorporated into the County's reengineering of the 2-1-1 Information and Referral (I&R) service model.

TAY Hub and I&R Services Request For Proposals

The August 18, 2020 memo stated that the CEO, Chief Information Office (CIO), and other departments and entities named in the TAY Hub motion were in the process of drafting an I&R Services Request for Proposals (RFP) document. The I&R Services RFP contained the technical requirements and specifications needed to facilitate the creation and ensure the sustainability of the TAY Hub, including the following features and capabilities:

1. Comprehensive, up-to-date registries of County/non-County services and providers;
2. More robust/user-friendly methods for users to access information and resources whenever needed (e.g., via telephone, text, instant messaging, online chats, self-service portals, etc.); and
3. A shared platform for initiating, tracking, and communicating the outcomes of client-service referrals among County and non-County providers.

On February 11, 2021, the County released its I&R Services RFP. Currently, the County is in the process of evaluating responses received, with the goal of selecting a vendor and entering into negotiations by the end of August 2021, and securing a new I&R contract before the end of December 2021, which is when the existing I&R contract is set to expire. If negotiations extend beyond the projected timeframe, the Board approved an extension of the existing contract with the existing service provider.

Once the new I&R Services contract is finalized, the I&R contractor will implement the following three Workstreams:

- Workstream 1: Establishment of 2-1-1 Call Center Services;
- Workstream 2: Deployment of self-service 2-1-1 Portal, TAY Hub Portal, and Community Provider Portal; and
- Workstream 3: Special Projects (e.g., Health and Human Services, disaster/emergency services campaigns).

Additionally:

1. The TAY Hub Steering Committee will reconvene to guide the development, testing, and rollout of the TAY Hub. The TAY Hub Steering Committee is comprised of representatives from various County departments and entities, philanthropy, current and former TAY, and non-County stakeholders and advocacy organizations.

2. The CIO will continue to build on the significant progress that has been made toward the development of the Los Angeles County Community Information Exchange (LACCIE). LACCIE is a behind-the-scenes information and communication brokering technology that bridges the service-referral communication gap between TAY, caregivers, County staff, community service providers, and stakeholders. LACCIE will make information exchange functions of the TAY Hub (and future portals) a reality.

3. The CEO and the CIO will continue to work with the interdepartmental I&R Steering Committee to guide the development and rollout of the three I&R service Workstreams. The I&R Steering Committee is comprised of the OCP and the Departments of: Children and Family Services; Health Services; Mental Health; Public Health; Public Social Services; and Workforce Development, Aging and Community Services.

Next Steps

The CEO will continue to work with CSP to engage philanthropy to identify potential areas of collaboration related to the TAY Hub development and rollout. The CEO will also work with County departments to develop MAPP goals for streamlining the delivery of TAY Hub-related services and promoting use of the TAY Hub.

Furthermore, since the TAY Hub is linked to the new I&R service delivery model, TAY Hub-related updates will be incorporated into future reports on the status of I&R service implementation.

Should you have any questions concerning this matter, please contact me or Tiana Murillo, Assistant CEO, at (213) 974-1186 or TMurillo@ceo.lacounty.gov.

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